Third Party Liability In The Medicaid Program

A Guide To Successful State Agency Practices

U.S. Department of
Health and Human Services
Health Care Financing Administration
Medicaid Bureau

September 1990

ACKNOWLEDGMENT

The Health Care Financing Administration (HCFA) wishes to extend its appreciation to the Directors and staff members of the third party liability (TPL) units in all 50 States and the District of Columbia for their contributions and assistance in developing this guide. HCFA further acknowledges the support of the State TPL Technical Advisory Group, who made significant contributions to the project.

We also gratefully acknowledge the efforts of the Federal and State work group members who contributed to this revision: Alfred Czerski, HCFA Central Office Coordinator (Baltimore); John E. Thomas, HCFA Central Office Representative (Baltimore); Gerald Rohifes (California), and Carolyn Link (Missouri), State Representatives; and Harold Finn (Boston), Kenneth Albrecht (Philadelphia), and Lavinia Peters (Seattle), HCFA Regional Office Representatives.

Lastly, HCFA would like to thank its own central office and Seattle Regional Office support staffs who labored many hours to prepare the guide for publication.

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INTRODUCTION

The intent of this "Best Practices Guide" is to provide State Medicaid agencies with information on exemplary practices which could assist States in improving their identification and pursuit of legally liable third party resources. More importantly, the Guide will enable State agencies to identify and assess those practices which have proven to be successful and are transferable to their own State operations. The Guide also makes available State agency reference data to assist States in determining comparability between Medicaid programs.

This is the third edition of the "Best Practices Guide." The original Guide was published in 1984. A second edition was published in 1987. The Guide is being updated again to reflect revisions to practices identified in the previous Guide, to add practices which have been implemented since 1987, and to include practices which are currently being tested in various States. The material in this Guide reflects the best information available as of June 1990.

Background

Federal law and regulations set forth in 42 CFR (Code of Federal Regulations), 433, Subpart D, require States to assure that Medicaid recipients utilize all resources available to them which are legally obligated to pay for all or part of their medical needs before turning to Medicaid. This may involve health insurance, casualty coverage resulting from an accidental injury, or payments received directly from an individual who has either voluntarily accepted or been assigned legal responsibility for the health care of one or more recipients.

The key to saving Medicaid dollars through TPL lies in identifying other insurance available to recipients. The regulations at 42 CFR 433, Subpart D, also require States to implement various activities to enhance the identification of liable third parties. These activities include (1) collecting health insurance information during the initial eligibility interview process; (2) participating in data exchanges with entities such as State wage information collection agencies and workers' compensation; and (3) conducting diagnosis trauma code edits to detect potential casualty and liability situations.

States use two methods to handle medical claims involving TPL: "cost avoidance" and "pay and chase". States cost avoid claims by requiring the provider of services to bill and collect from liable third parties before sending the claim to Medicaid. Pay and chase occurs when Medicaid pays the recipient's medical bills and then attempts to recover from liable third parties. States are required to cost avoid claims except in specific situations which are set forth in the regulations at Subpart D.

To The Reader Of "Third Party Liability In The Medicaid Program: A Guide To Successful State Agency Practices"

Notice Of Errata

This is to advise all readers of the Guide that there are three statutory references in State lien laws in the recently updated Guide which are in conflict with Federal law. The provisions in question are cited below. In essence, these provisions state that any recipient who initiates an action to recover damages or compensation from a liable third party shall receive no less than a certain fixed percentage of the total amount recovered after the deduction of attorney fees and costs.

The references are found in section IV of the Guide, entitled Successful State Practices, Part E, Model Legislation. Please note that only those paragraphs cited below are in conflict with the Federal statute, not the entire law, and that the sections should be annotated as being in conflict with Federal law:

Arkansas - Public Welfare Statute #83 - 171.1 C
District of Columbia - Health Care Assistance Reimbursement Act of 1984 - Section 8. Lien (c)
Iowa Code 498 - 75.4 (2)

The basis for legal conflict is found in section 1912 (b), of the Social Security Act. This section states that the remainder of any amounts collected under an assignment pursuant to section 1912 (a) shall be paid to the Medicaid recipient after the State recovers (with appropriate reimbursement to the Federal Government) what it paid on behalf of the recipient. The provisions in question could result in the State's recovering (and returning to the Federal Government) less than the full amount required under section 1912 (b). This conflict has only recently been called to our attention by counsel.

Arkansas has already repealed the referenced citations, and this reference, therefore, should be deleted from the Guide. With regard to the references for the District of Columbia and Iowa, those sections should be stricken as best practices. An annotation as to the conflict with Federal law in the absence of specific State provisions assuring full reimbursement of the Federal share based upon the total recovery, will suffice, with a cross reference to section 1912 (b) of the Act.

If the reader has questions with regard to this notice, please contact:

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Bureau of Quality Control
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6325 Security Boulevard
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ORGANIZATION OF THE GUIDE

Section I - State Successful Practices - This section contains new practices which have been implemented since the 1987 update. These "new" practices are identified by a single asterisk (*).

Section I also updates practices that were included in the previous Guide. Several States have adopted some of the practices and are being included in this update. The new States are identified by a double asterisk (**).

Section II - State Successful Practices Under Development - This "new" section will provide the users with the scope of practices that are being tested by States and should result in the more efficient use of Medicaid funds and eliminate duplication of effort.

Section III - Model Legislation - This section is divided into two parts as follows:

- o New State legislation, as well as updates on legislation previously submitted.
- o Legislation associated with specific successful practices described in section I.

Section IV - State TPL Training - This section identifies unique TPL training being conducted by States, as well as TPL manuals, publications, and video tapes.

Section V - State TPL Forms - This section includes various forms used by States to capture third party resource information.

Section VI - Federal and State Reference Data

- o Federal Reference Data - Part A of this section contains charts of the HCFA central office and regional office organizational structures, and describes the functional responsibilities of those components with Medicaid related functions.
- o State Reference Data - Part B of this section contains organizational charts depicting the functional alignment of each State's TPL unit, the contact person, and Medicaid program statistics.

THIRD PARTY LIABILITY IN THE MEDICAID PROGRAM
A GUIDE TO SUCCESSFUL STATE AGENCY PRACTICES

STATES' CONTRIBUTIONS

STATE	NUMBER OF SUBMISSIONS					SUBMITTED	
	STATE SUCCESSFUL PRACTICES			LEGISLATION		TRAINING MATERIAL	FORMS
	SECTION I		SECTION II	SECTION III		SECTION IV	SECTION V
	Prev	New	New	Prev	New		
1. ALABAMA	3		1				YES
2. ALASKA		1					
3. ARKANSAS	1			1		YES	YES
4. CALIFORNIA	6	1		2		YES	YES
5. COLORADO	1						YES
6. CONNECTICUT			2	1			
7. DISTRICT OF COLUMBIA (D.C.)	1						
8. HAWAII						YES	
9. FLORIDA	2						YES
10. IDAHO		1					
11. ILLINOIS	2	4	2		2	YES	YES
12. INDIANA				1		YES	YES
13. IOWA	1						YES
14. KENTUCKY		1			1	YES	
15. LOUISIANA		1					
16. MAINE					1		
17. MARYLAND	2	3		1			
18. MICHIGAN	2	2		1			
19. MINNESOTA	1	1		3	2		YES
20. MISSOURI	2	1	1	2			
21. MONTANA	1			1			
22. NEW HAMPSHIRE		1					
23. NEW JERSEY	2	1		1			YES
24. NEW MEXICO	1						
25. NEW YORK	5	2	1	4		YES	
26. OHIO	2			2			
27. OKLAHOMA			1				
28. OREGON	1	4	1	1	3	YES	YES
29. PENNSYLVANIA	2					YES	
30. RHODE ISLAND	1						
31. SOUTH DAKOTA		1					YES
32. TENNESSEE							YES
33. TEXAS	2						
34. UTAH		1			3		
35. WASHINGTON	5		1	4			
36. WISCONSIN		1					
GRAND TOTAL	46**	27*	10*	25#	12*		

* *New Successful Practices Submitted in 1990. Total: Sections I, II, III equals 49.*

** *35 of these Successful Practices were previously implemented. The remaining 11 practices were implemented by the following States in 1990: Arkansas, California (2 practices), Maryland, Missouri (2 practices), New Jersey, New Mexico, New York, and Washington (2 practices).*

\# *17 Legislative Practices were previously implemented. The remaining 8 practices were implemented by the following States in 1990: California, Connecticut, Minnesota, Missouri (2 practices), New York, and Washington (2 practices).*

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NO SUBMISSIONS

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SECTION I

STATE SUCCESSFUL PRACTICES

PART A

Implementation of Cost Avoidance Method of Claims Payment and Cost Avoidance Practices

SECTION I - TPL PRACTICE A-1

Implementation of the Cost Avoidance Method of Claims Payment

ALAMAMA
FLORIDA
WASHINGTON

1. Abstract - Federal regulations published on November 12, 1985, require State Medicaid agencies to use the cost avoidance method of payment in circumstances in which they have established the probable existence of third party liability at the time a claim is filed. The regulation applies to all claims processed on or after May 12, 1986, unless a waiver was requested from, and approved by, the HCFA regional office. Except for services excluded through a waiver, or specifically excepted by Federal regulation, States must cost avoid claims if the probable existence of TPL has been established at the time the claim is filed. The effectiveness of the cost avoidance process hinges in large part on the accuracy of the TPL data base. States' approaches in developing a TPL data base depend upon the availability of data management support, specifics contained in the data base, and cooperation from the health insurance industry. Many States have an excellent TPL data base and cost avoidance system. We have chosen to describe three State practices in this Guide, with particular emphasis on developing a TPL data base.

2. Impact of Practice

   2.1 Affected Segment of Caseload:

   This practice impacts upon the entire case universe.

   2.2 Savings:

Unknown	ALABAMA
Unknown	FLORIDA
$27,279,279 (SFY 89)	WASHINGTON

3. Ongoing, Operational Annualized Cost

Unknown[1]	ALABAMA
Unknown[2]	FLORIDA
$96,000	WASHINGTON

[1]Costs cannot be separated from the payments to the fiscal agent.

[2]System cannot identify on-going costs.

4. Implementation Costs/Times

Unknown[3]	6 Months	ALABAMA
$230,000	6 Months	FLORIDA
Unknown[4]	6 Months	WASHINGTON

[3]Implementation was part of the Medicaid Management Information System (MMIS) development. Costs cannot be isolated.

[4]Implementation costs cannot be determined at this time.

5. State Specific Features

ALABAMA

Alabama's cost avoidance system was developed in 1980, and is based upon a comprehensive TPL data base. The data base, also known as the policy file, contains in excess of 50,000 person specific records containing health insurance data.

When the Third Party Section learns of potential health insurance, an insurance code is added to the eligibility file. This code, when used alone, means that the insurance has not been verified. The code specifically identifies five carriers; all other carriers are identified as "other". This code is used in claims processing to identify claims that may need to be filed with the insurance carrier once verification of coverage is received. After the insurance code is added, an automated letter is generated to the insurance company or employer requesting verification of coverage. At the same time, an automated suspense file is created for followup to the insurance company/employer if no reply is received within a specified period.

When verifications are received, they are reviewed for accuracy, batched, and a record is added to the policy file. An additional code is added to the eligibility file designating that coverage has been verified.

Policy file records identify specific policy information to insure that claims are cost avoided with a minimum of errors. Each record identifies such policy information as policy number, policyholder, and effective dates. Limitation codes identify policies covering only cancer or accident diagnosis as well as Medicare supplemental policies. A source code identifies how

the third party information was referred; i.e., by Aid to Families of Dependent Children (AFDC) or Supplemental Security Income (SSI) caseworkers, specific data matches, court-ordered absent parent insurance, etc. It can be used as a management tool to identify the effectiveness of third party referral sources as well as claims processing edits for title IV-D related coverage.

Policy file records are very specific in terms of coverage. There are 20 coverage fields which are defined using one or more of the following: Diagnosis and procedure codes, types of service, place of service, and provider number format. Claims submitted to Medicaid, which meet the criteria for a covered service under a policy and have not been filed with the third party, are denied and returned to the provider with instructions to file with the third party.

FLORIDA

While Florida recently passed legislation providing for data matching with insurance companies, health maintenance organizations (HMO), and preferred provider organizations (PPO), that legislation is yet to be implemented, and the majority of information on TPL resources comes from Medicaid recipient questionnaires completed by caseworkers during eligibility determination and redetermination interviews, and from questionnaires completed by SSI recipients.

Those questionnaires provide information on the Medicaid recipient, the third party resource(s) and the departmental unit/employee submitting the document. Upon receipt, the Medicaid third party unit enters the information into the Florida Medicaid Information System (FMIS). Within FMIS, the TPL information is maintained by recipient, policy number, coverage type and effective date. A special code identifies the TPL resources maintained by absent parents (IV-D).

Once entered into FMIS, a verification indicator is used to determine whether the TPL resource is one of the following: Newly entered and unverified, verified as valid and available for cost avoidance, verified as not in force or invalid information, or trauma-related with specific selective coverage.

A five digit alpha/numeric code has been assigned to each TPL carrier maintained in FMIS. Monthly, all TPL resources with verification indicators of 1, and which have been on file for

less than 30 days or more than 90 days, are sorted and printed by carrier, policy number and individual covered. Various other pertinent information also appears on these printouts, which are mailed with cover letters to the appropriate carriers by the TPL unit. The window between 30 and 90 days is excluded to allow the carriers sufficient time to respond to the first request before another one arrives.

When returned to the TPL unit, these turnaround documents are used to change the verification indicators in FMIS to either a 2 or 3. Either of these changes results in an appropriate notice being system-generated for submittal back to the caseworker. Only those TPL resources with a verification indicator of 2 are used by the claims processing system for cost avoidance. Various statistical management reports are produced from this verification process. Provided to the IV-D agency is a report of all IV-D-identified coverage which lapsed or contained invalid information (verification indicator 3).

The monthly Medicaid ID cards show all verified TPL resources using the codes previously mentioned. Medicaid providers have been instructed and trained to convert those codes (carrier and coverage) to meaningful data by using billing manuals provided by the Medicaid fiscal agent. They have also been instructed that they must bill those TPL resources prior to Medicaid if a likelihood exists that the TPL resource will pay for the services provided.

During claims processing, every claim not having a third party indicator is systematically examined for the availability of verified TPL resources for the recipient appearing on the claim. Within the claims processing system, a matrix relates the claim being processed (provider type, invoice type, and procedure code) to the verified TPL resource(s) available for an action. The appropriate action of either pay, pend, deny, or pay and list is then carried out. (Pay and list is presently used only in conjunction with EPSDT, prenatal and drug claims and TPL resources maintained by IV-D absent parents.)

Claims which have been billed to and denied by the TPL resource must be submitted with a copy of the denial for proper processing by the Medicaid fiscal agent. Those claims are pended for clerical review and disposition by the TPL unit. When necessary, the FMIS TPL resource file is updated at that time (e.g.; cancellation of coverage).

All matrix action codes of pay and list result in the paid claims information being accumulated for monthly carrier billings. The system also processes all newly verified TPL resources against paid claims histories and extracts those paid claims which would have been cost avoided. Those monthly billings are sorted by insurance carrier and policy number and contain other pertinent information. These billings are mailed by the TPL unit directly to the carriers with cover letters in a manner similar to the verification turnaround document process.

WASHINGTON

When TPL is probable, the submitted claim is denied and a remittance advice is sent to the provider giving him/her the name and address of the insurance carrier, the name and Social Security Number (SSN) of the insured, and the policy number.

Resubmitted claims utilize a "claim adjustment" form which facilitates tracking the original against the resubmission. When an adjustment comes in after a claim was finalized (denied, paid in full, or paid in part), the original entry in the history file is modified to reflect actions by insurers. Dollar savings are tracked from submitted claims and adjustments, based on the amount actually paid by the insurance carrier. Denied claims, which are not resubmitted, are assumed to be fully cost avoided at the Medicaid allowable rate.

SECTION I - TPL PRACTICE A-2

Advance Warning Report to Ensure Timely Enrollment in Medicare — **CALIFORNIA NEW YORK**

1. Abstract - Each month the Medicaid eligibility systems in California and New York produce lists of Medicaid recipients who will reach their 65th birthday in 3 months' time. Upon receipt of the lists, county workers are responsible for communicating with each recipient and urging him/her to apply for Medicare benefits timely. Once the recipient is enrolled in Medicare, that fact is recorded in the TPL file of the State's claims processing system.

While this practice operates as part of a sophisticated data processing environment, it could easily be adapted to a partially or totally manual operation as long as a date of birth tickler file can be established. Most States should have no problem generating the warning list by computer, but this is not essential.

2. Impact of Practice

2.1 Affected Segment of Caseload:

This practice has potential impact on every recipient who is within 3 months of his or her 65th birthday.

2.2 Savings:

It is not possible to estimate the value of dollar savings directly attributed to this practice. (New York estimates that for each recipient who fails to apply for Medicare benefits, approximately $3,200 of Title XIX funds are overpaid each year.)

2.3 Other Benefits:

This practice enables the State agency to keep track of all recipients who are about to become eligible for Medicare and to assure that they are aware of their eligibility. In addition, should any recipient fail to apply, the agency will be aware of that omission and be in a position to deal with it.

Reminding recipients of their coming Medicare eligibility 90 days prior to their 65th birthday enables them to apply on the earliest date allowed and leaves

3. Ongoing, Operational, Annualized Cost

Unknown[1]	CALIFORNIA
$2,300	NEW YORK

[1]Cost cannot be isolated from total eligibility system operating costs.

4. Implementation Costs/Times

Unknown	Unknown	CALIFORNIA
$2,900	6 Months	NEW YORK

5. State Specific Features

CALIFORNIA

California's eligibility system tracks the identity of the caseworker assigned to each recipient. The Medicare enrollment warning reports are, therefore, directed to individual caseworkers who initiate action to ensure that each recipient makes an application for Medicare coverage or, if the recipient already has a Medicare Health Issuance (HI) claim number, submits a change to update the eligibility files.

NEW YORK

New York's eligibility system tracks recipients by county of residence. Medicare enrollment warning reports are directed to county offices where they are reassigned to individual caseworkers.

Cost Avoidance of Accident Claims * NEW HAMPSHIRE

1. Abstract - Current HCFA instructions require that, after the State has paid accident and diagnosis/trauma claims, it must initiate possible recovery within 45 days for any claim above the State's approved threshold, as specified in the State plan. New Hampshire, however, cost avoids accident claims. The MMIS contractor suspends payment on any claim that has any indication of accident; the TPL unit reviews the claims within 48 hours and, claims which are not cleared for payment, are held while the recovery system is initiated. This includes contact with the recipient, identification of the responsible insurer, contact with attorneys, and followup on all claims resulting from the injury. Providers are instructed to forward future and continuing treatment bills directly to insurers or attorneys, as applicable. The MMIS monitors all bills for involved recipients until all issues are finally settled.

2. Impact of Practice

2.1 Affected Segment of Caseload:

This practice impacts on that part of the caseload requiring medical treatment as the result of an accident, and involves about 1.6 percent of total claims processed.

2.2 Savings:

Savings are measured in terms of dollars cost avoided ($138,000), and recoveries from accident settlements ($310,000). No comparison to a "pay and chase" system is possible.

2.3 Other Benefits:

In addition to cost avoiding thousands of dollars worth of claims, New Hampshire has determined that early pursuit of accident claims results in greater likelihood of identifying and collecting from liable third parties. Also, the efficiency of cost avoiding results in staff savings with regard to time and money.

3. Ongoing, Operational, Annualized Cost

$30,000 (TPL Staff) (System cost - unknown)

4. Implementation Cost/Time

The cost is unknown because it cannot be isolated from the total cost for the fiscal agent. The time also cannot be determined because an ongoing system was enhanced when New Hampshire contracted with the fiscal agent. The best estimate is 3 - 6 months.

SECTION I

STATE SUCCESSFUL PRACTICES

PART B

Recovery Practices

SECTION I - TPL PRACTICE B-1

Probate Recoveries from Estates of Deceased Recipients

CALIFORNIA
MARYLAND
** MISSOURI
MONTANA
NEW JERSEY
** NEW YORK
OREGON
** WASHINGTON

1. Abstract - Most States apply SSI criteria to real property resources in determining the financial eligibility of aged Medicaid applicants/recipients. Thus, they generally exclude the value of property that is utilized as the residence of the recipient or a dependent family member from the financial computation. Several such States, however, track the value of such property through probate upon the death of the recipient and attempt to obtain repayment for the cost of services given to the recipient prior to his or her death from any proceeds accruing to the estate of the deceased through sale or transfer of the property. (See 42 CFR 433.36.)

   The State Data Exchange (SDX) includes a death indicator. Also, the Social Security Administration (SSA) has developed a national Death Master File. SSA district offices have the capability to query the file. States may make arrangements with SSA to receive copies of the Death Master file and updates. States interested in obtaining more information should contact:

   Jo Anne Harris, Match Manager
   SSA Death Master File
   Office of Retirement and Survivors Insurance
   Social Security Administration
   Room 3-A-21, Operations Building
   6401 Security Boulevard
   Baltimore, Maryland 21235
   (301) 965-7970

2. Impact of Practice

   2.1 Affected Segment of Caseload:

   This practice has potential impact on every aged Medicaid recipient who owns property that has been excluded under State eligibility rules. It can also be applied to the non-aged population if institutionalized services were paid by Medicaid.

2.2 Savings:

$22 Million	CALIFORNIA
$1.3 Million	MARYLAND
$500,000	MISSOURI
$220,000	MONTANA
$695,000	NEW JERSEY
Unknown[1]	NEW YORK
$5.5 Million	OREGON
$24,500	WASHINGTON

[1]Savings are not segregated by type of recovery.

2.3 Other Benefits:

In addition to yielding a large return in recovered program expenditures, this practice also appears to have a minor deterrent effect in discouraging applicants with property from applying for Medicaid to cover nursing home care. Many potential applicants (or their relatives) prefer not to have the State agency file probate claims against the applicant's estate and they decide not to apply for Medicaid to avoid such actions.

It is worth noting that States presently have the option under 42 CFR 433.36 to place liens against the residential property of a recipient while he or she is still alive. The States referred to here, however, believe that delaying the filing of a claim against the value of a recipient's real property until he or she is deceased avoids highly sensitive questions concerning the rights and the dignity of the individual, without materially affecting the eventual value of the State's claim or the ability of the State agency to recover Medicaid payments.

3. <u>Ongoing Operational, Annualized Cost</u>

$1.2 Million	CALIFORNIA
$116,743	MARYLAND
Unknown	MISSOURI
$10,000	MONTANA
Unknown[2]	NEW JERSEY
Unknown	NEW YORK
$437,000	OREGON
Unknown	WASHINGTON

[2]New Jersey does not track the cost of this practice apart from other recovery efforts.

4. Implementation Costs/Times

Unknown[3]	Unknown[3]	CALIFORNIA
Unknown	18 Months	MARYLAND
Unknown[3]	Unknown[3]	MISSOURI
None	None	MONTANA
Unknown[3]	Unknown[3]	NEW JERSEY
Unknown	Unknown	NEW YORK
Unknown[3]	Unknown[3]	OREGON
Unknown	Unknown	WASHINGTON

[3] In California, Missouri, New Jersey, and Oregon probate recovery activities evolved over many years, and it is not possible to estimate the cost of implementation.

State Specific Features

CALIFORNIA

California matches the "Discontinue Due to Death Flag" from each recipient's eligibility record against the State agency's vital statistics and master eligibility files to verify that a recipient is deceased and to identify client resources that may be subject to a recovery claim by the State. A computer-generated letter requesting information on the assets of the deceased recipient is then sent to next of kin identified in State files. In addition a Statewide microfiche listing of all real property is reviewed as a test of the integrity of the response. California legislation requires attorney notification in cases where a Medicaid recipient's estate is being probated. California seeks repayment of the cost of all medical services provided to the recipient after his/her 65th birthday, provided there is no surviving spouse, minor children, or blind or disabled children.

MARYLAND

In 1976, State legislation was enacted granting statutory authority to make estate claims in accordance with applicable Federal laws. Effective in 1979, the Registrar of Wills periodically notifies the third party recovery unit of all estates opened in Maryland. Timely notification permits the State to file estate claims. Maryland implemented TEFRA liens in 1986.

MISSOURI

In 1977, State legislation was enacted granting statutory authority to make decedent estate claims to recover public assistance payments. Notification is achieved in two ways. First, by a death match report from the Bureau of Vital Statistics against the Department of Social Services recipient file. The match reports are sent to county offices, after which the appropriate probate court records are reported and sent back to the Division of Legal Services for claim filing. Second, notification is received directly from personal representatives, attorneys, or public administrators. Claims are filed and cash only settlements or payments are received.

MONTANA

State agency staff keypunches identification data for all Medicaid recipients who appear in the paid claims history file, and prepares a tape that is matched against State mortality records. "Hits" are then reviewed for possible recoveries from the estates of deceased recipients. This allows identification of both current and former Medicaid recipients who have an outstanding public assistance debt.

Montana State law allows public administrators to initiate probate actions whenever they are not started by some other party. The State agency can then file for reimbursement of previously paid medical claims.

NEW JERSEY

The New Jersey Medicaid Program extends its probate recovery to the estates of all recipients, whether they resided in a nursing home or in the community. The eligibility records of long-term care recipients are reviewed by the Medicaid agency for property or other assets, while the estates of community recipients are sent a request for information such as the name of the estate attorney. Under New Jersey State law, the criteria for pursuing probate recovery are: (1) recipient is at least age 65, (2) the estate's value is at least $3,000, and (3) there were Medicaid payments of at least $500. Due to a recent court decision, if there is a surviving spouse or a natural or adopted child of any age, the State is barred from making a claim against the State. Also, under State statute, the Medicaid agency is empowered to file liens against all estates that meet these criteria. Such liens have the force and effect of a docketed judgement in the State Superior Court.

NEW YORK

An Estate Detection Report is produced on a monthly, county-specific basis after receipt of the SDX tape. It prints SDX information for only those recipients over 65 for which the SDX tape indicates both a death code and either a house/income producing property, or both, as a resource code.

The report is mailed to local districts where it is used to investigate and potentially recover funds.

OREGON

Oregon files a priority claim on the estate of every deceased recipient 65 or over, or upon the death of any surviving spouse, as long as there are no surviving children under 21 years of age, and blind or permanently and totally disabled individuals (using SSI rules). The amount of the claim covers all Medicaid services received since the recipient's 65th birthday and all State supplemental cash assistance paid to disabled recipients.

The claim is filed both with an attorney or other individual responsible for the disposition of the estate and with the court in which the estate is to be settled. The State considers the process to be virtually foolproof, in the sense that every available resource is captured with minimal effort.

WASHINGTON

In 1987, State legislation was enacted granting statutory authority to make claims against the estate in accordance with applicable Federal laws.

After the death of a recipient, a lien may be filed against their real property or a creditor's claim may be filed in probate action except (1) when there is a surviving spouse or surviving minor or dependent child, or (2) when there are surviving adult children, recovery will be limited to 35 percent of any estate value in excess of $50,000.

A monthly listing of deceased medical assistance recipients is received and the cases are researched to determine if the State has a claim within the parameters of the statute. Investigation is done to determine if there is a surviving spouse or surviving children, and their ages, to determine if there is property or other assets, and to gather legal descriptions, property values, and probate information.

SECTION I - TPL PRACTICE B-1

After the investigation and research is completed, the information is analyzed, and if the filing or a lien or creditor's claim is appropriate, it is then filed.

This is a relatively new program in the State of Washington, and, because of the timeframes involved in completing probate actions and disposing of real property, the dollar recovery amount is growing slowly. However, the value of the liens and claims filed each month is increasing, and recovery is expected to increase accordingly.

Release of Information by Providers

ALABAMA
ILLINOIS
IOWA
OHIO
PENNSYLVANIA

1. Abstract - Casualty related third party resources not known to the State may be identified through requests for medical reports and bills received by providers from attorneys, insurance companies and other parties. Some State require providers to contact the State agency before responding to such requests from insurance companies, attorneys, and other third parties. Some of these States control all such responses directly while others allow the providers to respond after referring the request to the agency for TPL followup.

   States use this practice as a "safety net" to catch what other identification procedures miss.

2. Impact of Practice

   2.1 Affected Segment of Caseload:

   This practice has potential impact on the entire case universe.

   2.2 Savings:

$300,000	ALABAMA
Unknown	ILLINOIS
Unknown[1]	IOWA
$4.3 Million	OHIO
$4.2 Million	PENNSYLVANIA

[1]Iowa cannot track specific savings from this practice; however, a substantial portion of its casualty recoveries are obtained in this way.

   2.3 Other Benefits:

   In addition to producing hard recoveries, this practice has a positive effect in terms of sensitizing providers, attorneys, casualty firms, and recipients to Medicaid's third party rules. When States adopt an aggressive recovery stance, all other parties involved in the process tend, over time, to cooperate voluntarily with State procedures and policies.

This practice also improves communications between providers and State agencies. What begins as a mandated restriction on release of information evolves into a two-way inquiry/response process that improves relationships and claims processing efficiency.

3. Ongoing, Operational, Annualized Cost

Minimal	ALABAMA
$72,000	ILLINOIS
None	IOWA
$707,000	OHIO
Unknown[1]	PENNSYLVANIA

[1]Pennsylvania is unable to isolate the cost of this practice.

4. Implementation Costs/Times

None	6 Months	ALABAMA
None	None	ILLINOIS
$1,000	8 Months	IOWA
None	None	OHIO
Minimal	6 Months	PENNSYLVANIA

5. State Specific Features

ALABAMA

Alabama has used this practice since 1971 to identify TPL missed by trauma edits and to insure that trauma claims are not settled before the State has an opportunity to intervene. This is mandated by rules issued by the State agency.

ILLINOIS

All requests received by providers for copies of medical histories and bills of Medicaid recipients received from attorneys, insurance company representatives, and other parties are referred to the Bureau of Collections for response. The State agency conducts ongoing educational efforts emphasizing the provider's responsibility to refer such requests to the third party unit so that potential third party resources may be identified.

IOWA

Iowa uses this practice to catch situations that are missed by trauma edits and to evaluate the effectiveness of those edits. Iowa also views this practice as an opportunity to educate providers on State procedures through training seminars. Additionally, in overcoming resistance from the Iowa Hospital Association on additional cost and reporting burdens, the State agency established a firm, no-nonsense posture with providers that improved the overall Medicaid relationship. The addition of a provider inquiry telephone line also has enabled providers to resolve, with a minimum of effort, a variety of questions which arise.

OHIO

Ohio uses this practice as a primary resource identification tool. The State agency follows up on all requests for documentation with a subrogation letter to the requesting attorney or liable third party. Ohio considers this practice to the most efficient way to utilize scarce personnel resources to identify casualty liability. Initial resistance from attorneys was overcome by competent and timely responses by State staff, who provided the requested claims documentation rapidly to all parties who observed State procedures.

PENNSYLVANIA

Pennsylvania requires providers to send all requests for documentation to the State agency. The agency controls all responses, establishes whether a recovery situation exists, and provides claims documentation after its case is established.

SECTION I

STATE SUCCESSFUL PRACTICES

PART D

Management Practices

SECTION I - TPL PRACTICE B-3

Use of Computer Generated Payment Histories in Lieu of Invoices for Billing Insurance Companies

ALABAMA
ILLINOIS
MICHIGAN
WASHINGTON

1. Abstract - Working with the Health Insurance Association of America (HIAA) and representatives of member commercial insurance companies, the State agencies in Alabama, California, Illinois, Michigan, and Washington designed computer claims histories that are accepted as billing documents by those firms. This enabled the agencies to retire their manual processes which required hard copies of invoices photocopied from microfilm.

HIAA has agreed, in principle, to accept electronically produced bills from all State agencies and many BC/BS Plans also have done so. State agencies should contact their local HIAA representative and BC/BS management to negotiate the exact format and content of computer generated bills.

2. Impact of Practice

2.1 Affected Segment of Caseload:

This practice has potential impact on the entire case universe.

2.2 Savings:

$281,360[1]	ALABAMA
$900,000[2]	ILLINOIS
$69,500[3]	MICHIGAN
$5,300,000[4]	WASHINGTON

[1]Represents recoveries on prescription drug claims for FY 88/89. Alabama recovers 33 percent of amounts billed to third party carriers.

[2]Illinois savings include averted State agency cost (90 percent) and averted county office costs (10 percent).

[3]Michigan's estimated cost for pulling appropriate hard copy bills.

[4]Washington's savings are estimates for SFY 89.

2.3 Other Benefits:

This practice represents an obvious efficiency for any State that utilizes an automated claims history file. In addition, while savings are recorded only in terms of directly reduced administrative costs, the real benefit of this practice is to make many more insurance billings and recoveries cost effective than would be otherwise.

3. Ongoing, Operational, Annualized Cost

$ 12,000	ALABAMA
$200,000[5]	ILLINOIS
$ 36,000	MICHIGAN
$ 48,000	WASHINGTON

[5]Illinois costs include personnel (40 percent) and computer usage (60 percent).

4. Implementation Costs/Times

There were no directly attributable implementation costs in any of the referenced States. The efforts involved in designing the reports and negotiating with insurance companies was considered a routine part of the TPL Unit's functions. In Michigan, California, Illinois, Alabama, and Washington, the programming required to generate the report was part of the MMIS development cost. (In Washington, the report was actually designed as part of an older MMIS system, and replicated in the new system that was installed in 1982.)

5. State Specific Features

ALABAMA

Alabama submits quaterly billings to insurance companies. This practice was implemented in 1980 and has consistently been a cost effective and easy method of recovery for drug claims.

ILLINOIS

The automated system creates about 30,000 billing each month. Hard copy is sent in duplicate to the carriers. The creation of the bill also creates an on-line Accounts Receivable that includes all the data on the hard copy bill. No paper claims are retained in the office. Tape alternatives have been used with several carriers and for Medicare Part "B".

NEW YORK

New York conducts quarterly matches with eight BC/BS plans and five commercial insurance carriers. Besides matching Medicaid recipients, absent parents who are paying support are also matched to identify health insurance for their dependents.

PENNSYLVANIA

Pennsylvania conducts matches with four BC/BS plans in the State.

RHODE ISLAND

Rhode Island conducts and matches with BC/BS plans in the State.

Hospital Audits Directed at
Detecting Medicaid Overpayments

** ARKANSAS
FLORIDA
** NEW MEXICO
TEXAS

1. Abstract - There is a common perception in many States that hospitals often receive insurance payments for the services that are paid by Medicaid which, for a variety of reasons, do not result in refunds to the State agency. Some States conduct periodic onsite audits of hospitals to identify unreported third party health insurance payments. After sending an advance listing of the records they want to review, audit teams spend an average of a week at each hospital to pull records and search for duplicate payments. Wherever this practice exists it appears to yield an extremely high payoff.

2. Impact of Practices

2.1 Affected Segment of Caseload:

This practice has potential impact on the entire case universe. For example, in FY 1986 in Florida, hospital providers accounted for $276 million or 27 percent of Florida's Medicaid expenditures.

2.2 Savings:

$ 311,584	ARKANSAS
$1,300,000[1]	FLORIDA
$ 132,866	NEW MEXICO
$ 98,000[2]	TEXAS

[1]Savings for 07/01/88 - 06/30/89: $1.3 million - approximately 220 hospital providers.

[2]Texas has had several years of savings experience with this practice, during which the amount of documented savings decreased steadily from the initial $750,000. The State agency believes, however, that this is due to the deterrent effect of providers anticipating a possible audit, and that if averted overpayments were counted, actual savings probably would have increased.

2.3 Other Benefits:

In addition to recovering overpayments, this practice alerts hospital business managers of the need to reimburse Medicaid whenever insurance payments are received for claims involving Medicaid recipients. To the degree that failure to reimburse Medicaid is a legitimate oversight, this helps to correct the omission. To the extent that such failure may not be accidental, hospitals are put on notice that Medicaid will take an aggressive position in pursuing such payments. Historically, this is known to have a considerable, but unmeasurable deterrent effect, if the agency is consistent in its pursuit. Another benefit is provider training. When requested by the provider, Florida's auditors conduct a training session for the hospital billing staff at the conclusion of the audit.

3. Ongoing, Operational, Annualized Costs

Unknown	ARKANSAS
$221,300	FLORIDA
Unknown	NEW MEXICO
$ 90,000	TEXAS

4. Implementation Costs/Times

$ 23,830 (flat fee)	ARKANSAS
Unknown	FLORIDA
$ 23,830 (flat fee)	NEW MEXICO
Unknown	TEXAS

There are no significant implementation activities or costs associated with this practice other than the normal preparation that occurs prior to a hospital audit.

5. State Specific Features

ARKANSAS

The estimated savings submitted for Arkansas ($311,584) is based on first-time audits.

The audits were performed by Certified Public Accountants (CPA) under contract with monitoring by the HCFA RO.

FLORIDA

Florida's staff (five full- time employees) performs at least an annual onsite audit of each Medicaid hospital provider to ensure proper provider billing and third party reporting and proper payment by the State's fiscal agent. Onsite audits are conducted in 1 to 5 work days.

NEW MEXICO

The estimated savings submitted for New Mexico ($132,866) is based on first-time audits.

The audits were performed by CPAs under contract with monitoring by the HCFA RO.

TEXAS

Texas now has sufficient experience with this practice that it is possible to begin to optimize the tradeoff between hard savings and their associated costs, and the deterrent savings that arise from averted overpayments. Texas presently is auditing institutions on an average of every 2 years to find the best mix of cost, audit savings, and voluntarily reduced overpayments.

Automated Recovery of Pharmacy Claims

* MARYLAND
* OREGON

1. Abstract - The States of Maryland and Oregon were granted waivers of cost avoidance for the payment of pharmacy claims. Through the development of automated systems for the recovery of paid pharmacy claims, both States have greatly improved the efficiency and effectiveness of the process.

2. Impact of Practice

2.1 Affected Segment of Caseload:

This practice impacts the recovery of Medicaid dollars affecting all Medicaid recipients with pharmacy benefits available through a third party resource.

2.2 Savings (Recoveries):

$296,000	MARYLAND
Unknown	OREGON

2.3 Other Benefits:

Implementation of these automated systems has proven cost-effective and has resulted in preventing undue disruption of processing pharmacy claims by preserving the normal claims adjudication process; thus resulting in timely payment of pharmacy claims and enhancing provider relations. In addition, recovery action has been initiated on a more timely basis which has expedited repayments as well as the crediting of collections. The opportunity to track unpaid claims and generate letters for followup also has occurred.

3. Ongoing, Operational, Annualized Cost

Maryland reports negligible ongoing costs which have consisted primarily of CPU time to run standard programs and the occasional use of a programmer analyst for problem solving. Oregon reports annual ongoing costs of $43,368.

4. Implementation Costs/Time

Minimal[1]	14 Months	MARYLAND
$1,800	3 Months (phase-in)	OREGON

[1]Implementation costs were minimal, consisting largely of the salary for one State programmer analyst to develop the program to create the claims tape and to apply the individual claim credits. The TPL unit negotiated the written agreement to submit pharmacy claims on tape. Implementation time was 14 months which was significantly influenced by the response time of BC/BS to test data.

5. State Specific Features

MARYLAND

Maryland submits pharmacy claims on computer tape to BC/BS of Maryland which is the single largest insurer of Maryland Medical Assistance recipients. The Program sends a tape of claims to the carrier each month and receives an annotated tape showing BC/BS payments and rejections and termination of benefits, along with a check for the approved claims. The annotated tape is used to update the coverage statements on the TPL subsystem and to credit collections.

OREGON

Prior to the automated system for the recovery of pharmacy claims, it took approximately three months to initiate recovery and also consumed an inordinate amount of staff time and delayed repayments. The automated system produces a ready-to-mail drug claim listing and transfers information from the mainframe to personal computer so that a data base for claims tracking is established with generates letters to all cases in less than one day. The actual recovery of Medicaid dollars on pharmacy claims has increased from approximately $20,000 to $40,000 per month, and during March 1990, an all-time record of $66,000 was recovered.

Every other month, the MMIS produces a printout of all drug claims which have been paid for which a third party resource is liable. The printout serves as the invoice(s). In addition to producing the drug printout, the system generates a data record for each individual, and transfers information to a floppy disk.

Information on the floppy disk is merged with an existing data base. A thousand records can be set up within a couple of minutes. The personal computer then generates letters to accompany the drug printouts. A separate file maintains the address of all insurance carriers. The data base also serves as a tickler file and will locate and send followup letters when no response has been received within 90 days of the initial request. A second followup letter is then prepared. The software will track recoveries and is capable of producing any number of reports for managing followup activities.

Details of Oregon's system are available upon request from the State.

Retroactive Recovery of Medicaid Funds Paid for Immunosuppressive Drugs

* CALIFORNIA

1. Abstract - Effective January 1, 1987, as a result of passage of the Omnibus Budget Reconciliation Act of 1986, Medicare began covering immunosuppressive (I/S) drugs prescribed within one year of hospital discharge. California established a program to recover Medicaid expenditures for such drugs. Because HCFA and the Medicare intermediary were unable to provide a list of Medicare eligibles for whom transplants had been paid a questionnaire was designed and mailed to all Medicare/Medicaid users of the covered I/S drugs to identify covered users and obtain the following information required by Medicare in order to process and pay claims:

- Date and type of transplant,
- name of transplant facility,
- date of hospital discharge,
- name and telephone number of transplant surgeon.

Responses to the questionnaires were screened to identify beneficiaries for whom I/S drugs could be billed. Using payment history, claims were prepared and sent to Transamerica Occidental, the Fiscal Intermediary responsible for Medicare Drug payments for beneficiaries living west of the Mississippi.

2. Impact of Practice

2.1 Affected Segment of Caseload:

This practice has potential impact on the Medicaid cost for beneficiaries who are recipients of a Medicare covered transplant and using I/S drugs in the year following transplant. It took three months to develop and implement the retro recovery program at a cost of $25,750 (Program, Data Processing and Billing Staff). The annual operational cost is approximately $8,800.

We will continue to pay and recover from Medicare until the claims payment system can be adapted to cost avoid this coverage.

2.2 Savings:

$720,000 1989

2.3 Other Benefits:

This practice lends itself to use of a "cost avoidance" method of claims payment through the establishment of "special" procedure codes.

3. Ongoing, Operational, Annualized Cost

$8,800

4. Implementation Cost/Time

$25,750 3 Months

(Cost involved Program, Data Processing,and Billing Staffs.)

Section I - TPL PRACTICE B-7

Retroactive Recovery of Medicaid Claims

* KENTUCKY
* SOUTH DAKOTA

1. Abstract - This practice involves retroactive recovery of Medicaid funds expended from the effective date of private HI coverage to the date the third party resource was discovered or the benefits became available. This is accomplished through an automated retroactive updating and billing process.

2. Impact of Practice

   2.1 Affected Segment of Caseload:

   Involves all Medicaid claims wherein a third-party resource was not previously identified.

   2.2 Savings:

$573,728 (FY 1989)	KENTUCKY
$196,793 (FY 1989)	SOUTH DAKOTA

3. Ongoing, Operational, Annualized Cost

Unknown	KENTUCKY
$ 19,990 (FY 1989)	SOUTH DAKOTA

4. Implementation Costs/Times

Unknown[1]	KENTUCKY
Unknown	SOUTH DAKOTA

[1]Cost for implementation of this practice is not available as it was part of other MMIS enhancements.

5. State Specific Features

KENTUCKY

During the final claims processing cycle each month, an automated billing is generated for each recipient case with a liable third party added to the on-line file for all retroactive cases. The billing data are generated and added to the case file, and each claim identified by an Internal Control Number (ICN) is given a status code indicating it was billed by the system.

The retroactive billings are generated from all recipient TPL data base policy updates that have a transaction within the previous month. Retroactive billings include claims paid back 2 years from the month the report is produced.

SOUTH DAKOTA

The third party unit receives a notice of possible retroactive cases primarily from three sources; i.e., (1) all refunds from providers are reviewed pertaining to individuals who did not previously have a private HI indicator on the MMIS; (2) a printout is received on all paid Medicaid claims where the paid amount represents only a deductible or coinsurance, and the individual has no third party indicator on MMIS; and (3) in addition, each time the Office of Child Support Enforcement imposes wage withholding on an absent father, an insurance query form is generated and sent to the employer with the withholding order. The form includes effective date of private HI for the children. All responses indicating coverage was effective prior to the initiation of the withholding order are forwarded to Recoveries and Investigations for followup action.

Use of a Uniform Billing Data Set and Flash-Printed HCFA 1500 for Insurance/Medicare

* NEW YORK

1. Abstract - Upon identification of retroactive insurance or Medicare coverage pertaining to a previously paid Medicaid outpatient claim, a flash-printed HCFA 1500 containing specific recovery data is generated for each affected recipient. These are then batched and mailed on a monthly basis to each appropriate insurance or Medicare carrier with an accompanying letter subrogation. Up to 160 insurance carriers can be billed in any particular month. An automated accounts receivable system tracks denials and payments by carrier.

   The uniform data set used in formulating the claims was devised in cooperation with HCFA, the America HIAA and the NYS Insurance Department. Prior to implementing this billing system, the data set was sent to fifty-six major insurance companies for their review and comments. Unique carrier-specific place and type of service codes were able to be incorporated into the billing system.

2. Impact of Practice

   2.1 Affected Segment of Caseload:

   This practice has potential impact on every Medicaid recipient.

   2.2 Savings:

   Approximately $1 million annually from Medicare and insurance.

   2.3 Other Benefits:

   Flash-printing forms at the same time as printing recovery data is less costly than using real HCFA 1500s. Getting the cooperation of HIAA in devising the uniform data set greatly enhanced participation by the carriers.

3. Ongoing Operational, Annualized Cost

   Since there is only limited manual intervention, the only cost is computer run time and mailing charges.

4. Implementation Costs/Times

   Approximately $80,000 in salaries and computer time over an eight month period.

Data Match With Motor Vehicle Accident Report * MICHIGAN

1. Abstract - The Third Party Liability Division - Casualty Section receives accident report data from the Michigan Department of Transportation and microfilm of all accident reports from the Department of State Police. These data includes severity of injury and reel and frame number where the accident report can be located on the microfilm.

   Microfilm copies are printed on all reports which contain injuries that are coded serious, fairly serious, or fatal. The injured parties, which include passengers as well as drivers, are checked against our eligibility file. A payment history is requested on all positive hits. Medical payments in excess of $300 for accident related injuries have cases set up for followup investigation.

   With Michigan being a "No-Fault State, several steps in the order of priority must be exhausted in pursuit of the liable carrier. In the absence of a liable no fault carrier, the case is referred to our Assigned Claims Facility for assignment and processing. After this determination, we submit our bills/charges to the assigned automobile insurance carrier for review and payment.

   Over the past year, an average of 9,000 accident reports were viewed on microfilm each month with 4,400 printed and checked against our eligibility file. We request an average of 525 payment histories which result in 36 case setups each month.

   The recoveries resulting from this process alone for FY 88/89 amounted to $1,440,136.85. This is nearly 30 percent of the total recoveries received in the automobile/no fault category.

2. Impact of Practice

   2.1 Affected Segment of Caseload:

   Impacts all Medicaid recipients involved in motor vehicle accidents.

   2.2 Savings:

   $1,440,137 (Fy 88/89)

   2.3 Other Benefits:

   Matches may identify income which impacts on Medicaid recipient's eligibility.

3. Ongoing, Operational, Annualized Cost

Unknown

4. Implementation Costs/Times

Unknown

5. State Specific Features

A payment history is requested on all positive hits. Medical payments in excess of $300 for accident related injuries have cases set up for followup investigation.

Since Michigan is a "no-fault State", several steps in the order of priority must be exhausted in pursuit of the liable carrier. In the absence of a liable no fault carrier, the case is referred to our assigned claims facility for assignment and processing. After this determination, we submit our bills/charges to the assigned automobile insurance carrier for review and payment.

SECTION I

STATE SUCCESSFUL PRACTICES

PART C

Identification of Resources

Eligibility Matches With Blue Cross/ Blue Shield (BC/BS) Plans and Other Private Insurers

CALIFORNIA
COLORADO
** MARYLAND
MICHIGAN
** NEW JERSEY
NEW YORK
PENNSYLVANIA
RHODE ISLAND

1. Abstract - State Medicaid files are matched against BC/BS and other private insurers to verify that all covered applicants are flagged in the Medicaid files and that all flagged Medicaid recipients have valid coverage. Any conflicting information is corrected in recipient eligibility files and TPL data bases. Verified coverage information is also entered on recipient identification cards to assist providers with cost avoidance billings to BC/BS and other private insurance carriers.

   In general, most insurors are willing or can be convinced to perform data matches to the extent they are able, if State agencies cover the costs involved. Often, the most significant issue is determining which entity sends its files to the other. Usually, the carrier is unwilling to release its files, allegedly for reasons of privacy, and State agencies agree to send a tape (or equivalent medium) to the carrier (if allowed by government confidentiality requirements).

2. Impact of Practice

   2.1 Affected Segment of Caseload:

   This practice has potential impact on the entire case universe.

   2.2 Savings:

   It is not possible to evaluate program savings that are directly attributable to this practice because States cannot determine how many "hits" obtained in this manner would have been obtained from other sources.

   2.3 Other Benefits:

   This practice assures that all coverage held by the insurors involved in the file match is known to the State agency with a minimum of delay. There is also an important but more subtle benefit that derives from the confidence level of the State agency, the providers,

and BC/BS, and other private insurers that when Medicaid says a recipient has coverage, that information is almost always accurate, and coverage start and end dates are updated timely. Thus, providers react to a claim that is denied by Medicaid with BC/BS or other insurance coverage indicated, knowing that payment will usually be received quickly and easily. The State agency knows that most its denials will not result in costly follow up activities, and the carrier knows that it will receive mostly clean claims.

3. Ongoing, Operational, Annualized Cost

$33,500	CALIFORNIA
$ 2,600	COLORADO
Negligible	MARYLAND
$ 3,500	MICHIGAN
Unknown	NEW JERSEY
$28,000	NEW YORK
$ 9,616	PENNSYLVANIA
$15,000	RHODE ISLAND

[1]This figure represents 7 matches with four separate entities (including BC/BS, Equicor and the Public Employers Retirement Systems).

4. Implementation Costs/Times

Included in Contract	Costs	CALIFORNIA
$13,268	6 Months	COLORADO
Minimal	17 Months	MARYLAND
$34,500	Minimal	MICHIGAN
Unknown	Unknown	NEW JERSEY
$36,000	3 to 6 Months	NEW YORK
$28,400	6 Months	PENNSYLVANIA
$15,000	4 to 6 Months	RHODE ISLAND

5. State Specific Features

CALIFORNIA

In addition to BC/BS matches, California matches files with other private insurance companies and has a subcontract with Health Management Systems (HMS) to conduct data matches for the purpose of retroactive billing. Information received from HMS will also be used to update current eligibility files with TPL information.

COLORADO

Data matches are conducted with BC/BS.

MARYLAND

A total of 1,500 recipients were identified during FY 1989 as having BC/BS of Maryland coverage which were unknown prior to the data match.

MICHIGAN

In addition to a monthly verification match, Michigan performed a quarterly eligibility match. The State also has an on-site BC/BS eligibility terminal.

NEW JERSEY

Annual State Medicaid budget appropriations have included the following language for several years: "It is further recommended that, notwithstanding any State law to the contrary, any private health insurance carrier writing health insurance policies in the State shall permit the Division of Medical Assistance and health Services (DMAHS) to match its Medicaid eligibility file against any private health insurance carrier's policyholder file." To this end, DMAHS conducts its own crossmatches with New Jersey BC/BS; additionally, DMAHS authorizes its TPL contractor to conduct file crossmatches with other private insurors on its behalf, with the recovery results listed below:

TPL CONTRACTOR RECOVERIES

	SFY '90 (7/1/89-3/16/90)	SFY '89 (7/1/88-6/30/89)
Medicare A	$1,828,943	$2,476,283
Medicare B	176,299	205,945
Aetna	157,080	81,025
CHAMPUS	13,375	223,965
Confederation Life	339	4,519
Connecticut General	27,596	184,245
Equicor	337	----
Lincoln National	9,385	----
Metropolitan	42,982	118,736
TOTAL	$2,256,336	$3,294,718

NEW YORK

New York conducts quarterly matches with eight BC/BS plans and five commerical insurance carriers. Besides matching Medicaid recipients, absent parents who are paying support are also matched to identify health insurance for their dependents.

PENNSYLVANIA

Pennsylvania conducts matches with four BC/BS plans in the State.

RHODE ISLAND

Rhode Island conducts and matches with BC/BS plans in the State.

SECTION I - TPL PRACTICE C-2

Data Matches With Other State Agencies to Identify Health Insurance Coverage

** CALIFORNIA
** MISSOURI
OHIO
WASHINGTON

1. Abstract - All States offer current employees some form of health or major medical coverage, and several extend those benefits to retirees. Where State agencies which monitor these programs have a useable data base, Medicaid agencies can match against it to locate Medicaid recipients who are covered by another State program. Matches of this type are required by 42 CFR 433.138. Examples of matches for current employees' coverage and retirees' coverage are presented below.

2. Impact of Practice

2.1 Affected Segment of Caseload:

This practice has potential impact on the entire case universe.

2.2 Savings:

$200,000[1]	CALIFORNIA
$786,000	MISSOURI
$900,000	OHIO
$1.65 Million	WASHINGTON

[1]Annual savings of $200,000 is based on 4 months of Medicaid eligibility per person at an estimated savings of $60 a month per person.

2.3 Other Benefits:

Matches may identify income (pensions) which impacts on the eligibility of a recipient.

3. Ongoing, Operational, Annualized Cost

$ 6,800	CALIFORNIA
$18,000[2]	MISSOURI
$31,000	OHIO
$ 1,440	WASHINGTON

[2]The increased annualized cost is due to computer enhancements. Future annual ongoing costs are expected to be minimal.

4. Implementation Costs/Times

Unknown	Unknown	CALIFORNIA
$20,500	Annual	MISSOURI
None	10 to 12 Mo.	OHIO
$11,300	3 Months	WASHINGTON

5. State Specific Features

CALIFORNIA

California has a multi-year contract with the State's Public Employees Retirement System (PERS) which contracts with a variety of health benefits plans. PERS provides health benefits and retirement administration to employees and retirees of the State, as well as employees and retirees of contracting government agencies. Every nine (9) months, a data match against the State's Medicaid eligibility extract file and the PERS file is conducted.

Initially, PERS resisted contracting with the Department of Health Services because of confidentiality concerns. The Department therefore initiated enabling legislation requiring PERS to allow access to its file. The Department then addressed confidentiality issues through the two Departments' legal counsel. The Department pays PERS all costs associated with doing the data matches, including development and ongoing computer cost.

MISSOURI

Missouri TPL has conducted its initial data match with Missouri State Retirement System Plan in 1988. The information obtained allows for automatic entry the State TPL Data Base and MMIS eligibility files and for comparison of known health insurance to determine necessary updates to Medicaid files. The information is utilized for cost avoidance of future claims and recovery activities of Medicaid expenditures from Missouri State Medical Care Plan and other coverages.

The number of Medicaid recipients having health insurance identified totaled 1,430. Recoveries to date total $786,000, with anticipated total recoveries of $950,000. In addition, undetermined amount of savings are realized in cost avoidance.

OHIO

Ohio's public employees' retirement system offers retirees health insurance benefits for life, available from a single carrier, statewide. Once each year, Ohio matches its recipient file against the retirement systems file of enrollees. For each match, the State agency submits claims histories to the carrier.

Initially, the State Retirement System resisted the data match because of privacy considerations, and because of a disagreement over which agency would pay to generate the tapes required to perform the match. These were resolved when the State Medicaid agency agreed to accept legal liability for all privacy problems, and split the cost of the match by agreeing to pay for running the match if the Retirement System paid for generation of the tape.

The Retirement System is run by a fiscal intermediary (FI) on a self-funded basis. Thus the FI was at risk for total payments and was initially not cooperative; for example, the FI refused to accept computer generated bills. The State agency maintained a tough stance, and ultimately prevailed, but the final agreement provided for payments of only 80% of the amount asked for by Medicaid. This is in line with payments made by the FI to providers; thus, the FI won the right to treat the State agency as though it were a direct-billing provider.

WASHINGTON

A match of two data files is performed every 3 months to determine which Medicaid recipients or absent parents of recipients are employed by the State of Washington in a capacity that provides health insurance resources for themselves or their recipient children. A file of names, social security numbers, and birth dates of Medicaid recipients and absent parents is matched against a file of State employees who are covered by insurance. The result is a list of insured recipients and absent parents and their covered dependents. Questionnaires are then mailed to employees for necessary details on dependent coverage, policy numbers, effective dates, etc.

SECTION I - TPL PRACTICE C-3

Identification of Accident Related Third Party Resources Through Coordination With Ambulance Service

DISTRICT OF COLUMBIA (D.C.)

1. Abstract - the District uses the Fire Department accident reports to identify third party resources. The D.C. Fire Department, which provides ambulance services, furnishes the TPL Estates Section with copies of accident reports involving D.C. Medicaid recipients. These reports are submitted to the TPL section on a weekly basis. The practice ensures the filing of claims and liens against third parties before damages can be sought or payments made to the recipient. Its greatest value is an increase in TPL collections.

2. Impact of the Practice

   2.1 Affected Segment of Caseload:

   This practice has potential impact on the entire case universe.

   2.2 Savings:

   Annual dollars recovered during FY 89 for casualty cases totaled $731,010.

   2.3 Other Benefits:

   Use of the Fire Department ambulance accident reports has enhanced the TPL staff's ability to obtain accident reports from the Department of Motor Vehicles (DMV) by providing time and location of each injury. The DMV reports contain the name of casualty insurance companies, policy numbers and an indicator when a claim has been filed. This allows TPL staff to seek recovery without agency/client contact.

3. Ongoing, Operational, Annualized Costs

   Minimal

4. Implementation Costs

   There are no implementation costs attributable to this practice. The State agency and the D.C. Fire Department are both components of the District government.

5. Additional Information

The D.C. Fire Department provides ambulance transportation to approximately 95 percent of the District's total population; 13 percent of the District's population are Medicaid recipients. The Fire Department staff routinely verify the eligibility of each client before billing the Medicaid program; therefore, the additional effort to provide reports to the State agency in minimal. The TPL Section averages 35 accident reports per week with an average of two having potential TPL.

SECTION I - TPL PRACTICE C-4

Data Match with Department of Defense-Defense Enrollment Eligibility Reporting System (DEERS) for the Purpose of Identifying Medicaid Recipients Who Are Also Eligible for Military Health Care Benefits Including Office of Civilian Health and Medical Programs of the Uniformed Services (OCHAMPUS)

* LOUISIANA
* MARYLAND
* MICHIGAN
* MISSOURI
* NEW JERSEY

1. <u>Abstract</u> - In 1985, HCFA negotiated an agreement with the Department of Defense (DOD) and CHAMPUS and DEERS which facilitates Medicaid reclamation from CHAMPUS. A significant portion of Medicaid recipients and their dependents are covered by CHAMPUS for many of the services for which Medicaid pays.

2. <u>Impact of Practice</u>

   2.1 **Affected Segment of Caseload:**

   The CHAMPUS/DEERS matches have potential impact on a significant fraction of a State's Medicaid population. States with active military facilities, bases, and other military installations where active service personnel are stationed, and States with a large numbers of retired military personnel are likely to find greater numbers of CHAMPUS covered Medicaid recipients and have greater TPL recovery potential.

   2.2 **Savings:**

$267,000	Louisiana
$273,000	Maryland
$506,000	Michigan
$545,000	Missouri
$187,000	New Jersey

   2.3 **Other Benefits:**

   In addition to yielding sizable TPL recovery revenue, this practice is highly cost-effective in that DEERS provides a centralized data base for identifying CHAMPUS eligibles. Data matches to this data base can be readily done through an established protocol. However, billing of claims to the CHAMPUS fiscal intermediary assigned to a particular State must be done to conform to the specifications of that intermediary. These specifications are functionally the same, but differ somewhat at the operational level from intermediary to intermediary.

3. Ongoing, Operational, Annualized Cost

Unknown	Louisiana
Unknown	Maryland
Unknown	Michigan
$23,070	Missouri
Unknown	New Jersey

4. Implementation Costs/Time

$40,000[1]	3 Months	Louisiana
$25,000[1]	3 Months	Maryland
$74,000[1]	3 Months	Michigan
$27,379	Unknown	Missouri
$26,000[1]	3 Months	New Jersey

[1]State implementation costs vary based on contingency fees paid to a contractor. The matches and billing are performed by a contractor which is paid a percentage of the actual recoveries obtained from CHAMPUS. The contracting firm for Louisiana, Maryland, Michigan, and New Jersey is Health Management Systems (HMS).

5. State Specific Features

MICHIGAN

Michigan's CHAMPUS TPL recovery is done via a protocol under which:

1. An automated match of the State's Medicaid eligibility files is done with DEERS to identify those Medicaid recipients who may be covered by CHAMPUS. The date of this match is set through a schedule arranged for by HCFA. The match is done by sending a magnetic tape to DEERS in California, which performs the match and returns the tape with match results to the State.

2. The file of DEERS match results are then matched to the Medicaid paid claims for the period of eligibility for which CHAMPUS coverage is indicated by the match results.

3. The matched claims are then formatted to the CHAMPUS intermediary's requirements and the CHAMPUS billing specifications manual. The claims are produced on paper bills (U-51s and HCFA 1500s) and mailed to the CHAMPUS intermediary.

4. The CHAMPUS intermediary adjudicates these claims, which usually takes 30-60 days. The intermediary then issues checks to the State agency and remittance advises documenting the initial disposition of each claim.

5. Denied claims are reexamined and rebilled if the reason for denial is correctable by adding further information or more current information.

MISSOURI

Missouri TPL has conducted three successful data matches with DEERS in the period of 1987-89. The information obtained allows for automatic entry into the State TPL data base and MMIS eligibility files and for comparison of known CHAMPUS coverage for any necessary updates to Medicaid files. The information is utilized for cost avoidance of future claims and recovery activities of Medicaid expenditures from the CHAMPUS intermediary. Computer generated billings are submitted to the CHAMPUS intermediary.

The number of Medicaid recipients having CHAMPUS identified total 3,734. Recoveries through the data match realized from SFYs 89-90 year-to-date total $545,000. In addition, undetermined amounts of savings are realized in cost avoidance.

SECTION I - TPL PRACTICE C-5

TPL Identification Through Review of Credit Adjustment Forms

* ILLINOIS

1. Abstract - Medical providers which receive a TPL payment for a service which has been paid by Medicaid return payments to the Department by submitting a credit adjustment form. The payment amount and the TPL source identification code are provided on the form, which requests the Department deduct the appropriate amount from future payment vouchers.

   The TPL source identification code is matched against the TPL data base to ensure that the Department is aware of the information. If the TPL resource does not appear on the data base, the provider is asked to provide TPL identifying information which is then added to the TPL data base.

2. Impact of Practice

   2.1 Affected Segment of Caseload:

   This practice has potential impact on all Medicaid recipients with unreported TPL. During FY 89, this review resulted in the identification of 1300 additional TPL resources.

   2.2 Savings:

   FY 89 $374,400

3. Ongoing, Operational, Annualized Cost

   Minimal

4. Implementation Costs/Time

   Minimal

Trauma-Indicating Diagnosis Codes
Outside of 800-999 Range

* WISCONSIN

1. Abstract - Diagnosis codes that serve to identify recipients having personal injury claims are not limited to the 800-999 range mandated for listing and investigation. On the other hand, a number of codes in the 800-999 range are not useful; most notably those relating to poisoning associated with alcohol and drug abuse which typically accompany AODA treatment. The following diagnosis codes that are outside of the mandated range are also worth reviewing and investigating:

003-003.9	289.7	366.2	521.2
440-004.3	323.7	388.1-388.2	558.2
005-005.9	348.1	495-495.8	655.6
027.2	357.7	500-508	760.5
287.4	359.4	518.5	798
E800-E876.9	V01.5	V15.6	V71.4
E880-E929.9	V04.5	V62.1	V82.5
E960-E969	V15.5	V71.3	

2. Impact of Practice

In the last 6 months of 1989, ten personal injury claims by recipients were identified using the pure numeric codes equal to less than 800. These were among 155 claims listing incidents in which investigation for recovery action reached closure, or 6 percent. During the same period, 26 personal injury claims were identified using the E and V codes. These were among 164 claims listing incidents in which investigation for recovery action reached closure, or 16 percent. By comparison, investigation of claims with diagnosis codes in the 800-999 range (not including substance abuse-related codes) identified 499 apparently recoverable cases among 2786 listings that reached closure, a success rate of 18 percent.

The cost of inclusion of the non-mandated codes is a matter of the time spent in questionnaire mailing and resulting tracking, analyzing replies received and referring for action. Based on the number of cases reaching closure, cited above, this computes to be an 11-percent increase in the trauma claims review effort with a 7-percent increase in cases identified. Note, however, that the success rate on E and V codes is almost equal to that of the 800-999 range.

SECTION I - TPL PRACTICE C-7

Identification of TPL Through
Employer Quarterly Reports * OREGON

1. Abstract - Oregon law affects information that employers are required to provide on the quarterly report along with details of employees' wages and weeks of work. For wages paid on or after January 1, 1990, employers are required to furnish information about health insurance coverage offered to employees or to their dependents.

2. Impact of Practice - As a result of this law, information about employment-related health benefits will be available in one place. The Employment Division (SWICA) will gather the information and share it with the Adult and Family Services Division through a data exchange beginning July 1, 1990. Information will be used primarily by the Child Support Program with information shared with the Medicaid program. It will help to identify previously unknown health insurance and will permit the State to concentrate on medical support enforcement in cases where medical insurance is available.

   With 50 percent employer compliance with the new reporting requirements, Oregon estimates the percentage of recipients with health insurance will increase 1 percent. With the identification of previously unknown resources, the agency will cost avoid an increasing number of medical claims. The net savings for 1989-91 biennium are estimated at $853,328 and for the 1991-93 biennium, $2,068,480.

3. Ongoing, Operational, Annualized Cost

   For the 1989-91 biennium the costs are estimated at $182,730 and for the 1991-93 biennium, $315,929.

4. Implementation Costs

   $25,000

A-Engrossed
House Bill 2142

Ordered by the House May 11
Including House Amendments dated May 11

Ordered printed by the Speaker pursuant to House Rule 12.00A (5). Presession filed (at the request of Adult and Family Services Division, Department of Human Resources)

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure.

[*Authorizes Department of Human Resources to obtain*] **Requires every employing unit to furnish to Employment Division health insurance information concerning coverage of** [*applicant for or recipient of medical assistance.*] **employes and dependents. Requires division to release such information to Adult and Family Services Division (AFS) and Office of Health Policy, upon request. Requires AFS to reimburse Employment Division for costs and to report to Sixty-sixth Legislative Assembly regarding such insurance information.**

A BILL FOR AN ACT

Relating to disclosure of insurance records.

Be It Enacted by the People of the State of Oregon:

SECTION 1. Section 2 of this Act is added to and made a part of ORS chapter 657.

SECTION 2. (1) With respect to wages paid on and after January 1, 1990, every employing unit shall furnish to the Employment Division, along with its quarterly detail of employes' wages and weeks of work, the following information:

(a) Whether the employing unit offers health insurance coverage to its employes or to their dependents, either through a self-insured program or an outside contractor; and

(b) For each employe or each employe's dependents, whether that employe has health insurance coverage provided by the employing unit or through payroll deduction.

(2) Notwithstanding any other provision of law, the Employment Division shall release to the Adult and Family Services Division and the Office of Health Policy, upon request, any information received under subsection (1) of this section. The Adult and Family Services Division shall reimburse the Employment Division for the actual cost of developing the reporting system and providing the information to the division.

SECTION 3. The Adult and Family Services Division shall report on the information described in section 2 of this Act to the Sixty-sixth Legislative Assembly by submitting copies of the report thereof to the offices of the Speaker of the House of Representatives and the President of the Senate.

NOTE: Matter in **bold face** in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted.

Evaluation of TPL Performance
at the County/Local Office Level

CALIFORNIA
NEW YORK

1. <u>Abstract</u> - Most effective cost avoidance systems draw heavily on the efforts of local or county welfare offices. Information about confirmed or actual insurance resources obtained by caseworkers is a major source of TPL savings. Evaluation of local office performance is one effective way to establish and provide incentive to maintain high quality and productivity in local office activities.

   California and New York (both operating Medicaid under county administration) have different approaches to evaluating county office inputs. California focuses on the number of referrals and the quality of the work done in terms of how easily the results can be utilized by the State agency. New York is more result-oriented, measuring the number of known resources and the amount of savings that are attributable to the information received from each county.

   Both States utilize a Statewide TPL data base to evaluate and compare the performance of local districts with respect to third party activities. The performance of any specified grouping of local districts can be tracked and reported. Both systems produce computer reports that enable State staff to evaluate performance, identify weaknesses, and plan corrective actions.

2. <u>Impact of Practice</u>

   2.1 Affected Segment of Caseload:

   This practice has potential impact on the entire case universe.

   2.2 Savings:

   There are no explicit savings directly attributable to this practice. Evaluation is a management tool designed to improve the overall performance of county workers who are depended on to identify TPL resources and properly report the information required by the State to do effective cost avoidance.

   2.3 Other Benefits:

   Two primary benefits accrue from this practice. First, a sense of competition and incentive among county offices is

created by the comparative reporting of performance statistics among the counties. Second, the State agency has a powerful management tool which permits detection of weak performers and highlights specific areas of weakness where attention and training are needed.

3. Ongoing, Operational, Annualized Cost

Minimal - (a virtually free by-product of the TPL data base systems).

4. Implementation Costs/Times

Unknown	Minimal	CALIFORNIA
$5,500	6 Months	NEW YORK

5. State Specific Features

CALIFORNIA

California's system evaluates referrals received from county and SSA district offices with respect to their volume and value to the overall TPL efforts of the State agency. For counties, the system counts the number of referral forms received and coded. For SSA, per the 1634 agreement, it counts the number of referrals received from each office, the percentage of referral forms that were received in useable (codeable) form, the percentage of the Medicaid population in each county that is reflected in the referrals, and the number of forms that had to be returned for corrections or further work.

California's cost avoidance evaluation data are maintained as part of the MMIS. For counties and for SSA district offices alike, it counts the number of TPL referral forms received each month, the number and percentages of referral forms that were codeable from those that required corrections, and then the percentage of the total Medicaid eligibles with recorded TPL.

NEW YORK

The Statistical Tracking and Reporting System (STARS) data base contains 42 specific data elements related to cost avoidance and the availability of insurance. These elements are reported either directly, or in combination with other elements in mathematical formulate, to derive various measures of TPL performance.

The most widely utilized of the STARS reports ranks all local district offices' performance with respect to 8 measures of detection and 4 measures of cost avoidance. The 12 general measures of performance presented in this and other reports are:

Recipients with known insurance (number and percent) broken out by program (public assistance, medical assistance only, SSI, total);

occurrences of insurance (number and percent) broken out by type of insurer (Medicare, Blue Cross/Blue Shield, commerical carriers, total);

amounts cost avoided (dollars and percent) broken out by source of payment (Medicare, other insurance, individual payment, total).

In addition, specialized measures of performance are derived and reported for STARS and other reports as required.

Use of Direct Recipient Mailout of Questionnaires to Detect TPL

TEXAS

1. Abstract - Federal regulations published February 27, 1987 require State Medicaid agencies to perform systems edits to identify those paid claims for Medicaid recipients that contain diagnosis codes 800 through 999 (International Classification of Disease, 9th Revision, Clinical Modification, volume 1 (ICD-9-CM)) for purposes of determining the potential casualty related legal liability of third parties. Conducting recipient interviews on diagnosis codes where potential cases exist costs approximately $25 per case. Instead of the case worker obtaining the details on these cases, Texas sends out a questionnaire directly to the recipient with a postage paid return envelope. The form (8702A) also includes a WATTS line telephone number.

2. Impact of Practice

2.1 Affected Segment of Caseload:

This practice has potential impact on all recipients involved in a trauma related injury.

2.2 Savings:

The practice has resulted in annual savings of $192,000.

2.3 Other Benefits:

The practice improves the overall efficiency of the TPL identification process.

3. Ongoing, Operational, Annualized Costs

$30,000 Annually

4. Implementation Costs

Minimal

5. Additional Information

Eighty percent of all the questionnaires are accurately completed and returned to the third party recovery unit. The case worker follows up to obtain the completed questionnaires from recipients who have not returned them.

Payment of Cost Effective Health Insurance Premiums for Medicaid Recipients

** CALIFORNIA
MINNESOTA
NEW YORK
** WASHINGTON

1. <u>Abstract</u> - Whenever an applicant or recipient of public assistance or medical assistance has health insurance in force covering care and medical benefits covered under Title XIX, full or partial payment of the premium for such insurance may be made by the State agency when making such a payment is deemed appropriate pursuant to the regulations of the Department of Social Services.

2. <u>Impact of Practices</u>

2.1 Affected Segment of Caseload:

This practice has potential impact on the entire case universe in that the practice permits the Medicaid State agency to continue a recipient's HI in force on a case-by-case basis. This has the effect of permitting the agency to pay premiums whenever it finds that doing so would be cost-effective to Medicaid. States that studied the problem generally found that many (and in some populations most) recipients who have insurance at the time of application cancel it upon being found eligible for Medicaid, because the program offers no incentive to continue paying premiums.

2.2 Savings:

$196,700 (6 months)	CALIFORNIA
Unknown[1]	MINNESOTA
Unknown	NEW YORK
$38,000/mo[2] $158,000/mo[3]	WASHINGTON

[1]Minnesota does not have the capability at this time to estimate costs; however, an automated system has now been installed which will enable computing future costs.

[2]Savings are stated for May 1990 and are for public assistance recipients. These savings include premium payments and administrative costs netted against actual and expected monthly program expenditures.

[3]Same criteria as number 2 except this population is not on assistance and are Class IV AIDS individuals. (See Washington specific write-up for further details).

3. Ongoing, Operational, Annualized Costs

Unknown	CALIFORNIA
Unknown	MINNESOTA
Unknown	NEW YORK
$33,119	WASHINGTON

4. Implementation Costs/Times

Unknown	CALIFORNIA
Unknown	MINNESOTA
Unknown	NEW YORK
Negligible	WASHINGTON

5. State Specific Features

CALIFORNIA

The California Health Insurance Premium Payment (HIPP) Program was enacted which permits the State Department of Health Services (DHS), when it is cost effective, to pay the insurance premiums for Medi-Cal beneficiaries with high cost medical conditions (e.g., cancer, Acquired Immune Deficiency Syndrome (AIDS), organ transplants, and other types of chronic or severe illness). This HIPP Program became effective August 1, 1989.

The Department must document cost-effectiveness before the HIPP Program can pay the premium costs. Cost-effectiveness is established when the monthly cost of care is at least twice as much as the monthly insurance premium and the policy covers the applicant's chronic medical condition.

From August, 1989 through January, 1990, 37 cases were approved for premium payment in California at a total cost of $43,300 in premiums, with an estimated net program savings of $196,700. Savings are based on average Medi-Cal high cost cases ($2,400 per month). Under-estimates are likely to occur since two HIPP participants received organ transplants and the minimum hospital costs for such a procedure are $150,000.

CALIFORNIA STATUTE

§14124.91 Payment of premiums for third-party health coverage by State Department of Health Services; time period to exercise options

The State Department of Health Services may, whenever it is cost-effective, pay the premium for third-party health coverage for beneficiaries under this chapter. The State Department of Health Services may, when a beneficiary's third-party health coverage would lapse due to loss of employment or change in health status or any other reason, continue the individual's health coverage by paying the cost of continuation of group coverage pursuant to Federal law, or converting from a group to an individual plan. Notwithstanding any other provision of a contract or of law, the time period for the department to exercise either of these options shall be 60 days from the date of lapse of the policy.

MINNESOTA

Following is a summary of Minnesota's State Statute involving the payment of health insurance premiums based on cost-effectiveness.

MINNESOTA STATUTE

Eligibility Factors: HI Premiums

Cost Effective Health Insurance(HI)

Medical Assistance (MA) funds are used to pay HI premiums determined to be cost-effective to DHS. Premium payment is initially made by the local agency.

Premium payments for HI may be made by the MA program if:

(a) the policy has been determined to be cost-effective by the benefit recovery section; and

(b) without payment of the premium by MA, the policy would be terminated due to the recipient's financial inability to maintain the policy; and

(c) the premium payment was not used as an employment expense or to meet the client's spenddown.

An HI policy is considered to be cost-effective if it appears that payment of the premiums would reduce MA expenditures by more than the cost of the premiums.

HI policies must be evaluated by the benefit recovery section for cost-effectiveness whenever MA funds are used to pay the insurance premium. The cost- effectiveness of a policy must be reevaluated by the benefit recovery section whenever there is a change in the premium payment amount and/or the level of coverage provided by the policy. The following information must be submitted by the local agency to the benefit recovery section to receive a determination of the cost-effectiveness of a policy.

(a) The recipient's name;

(b) the recipient's age;

(c) a copy of the actual and complete insurance policy;

(d) the premium amount and premium payment schedule;

(e) information relating to any chronic medical condition(s) and/or utilization of medical care by the recipient (including nursing home benefits/expenses),

(f) any extenuating circumstances, including estimated period of MA eligibility (is short term), or maternity leave from employment,

(g) information relating to actual expenses paid by the insurance carrier during the previous contract period (if available); determine if annual expenses paid by insurance exceed annual premium, and

(h) identify whether applicant/recipient is/will be enrolled in a Medicaid demonstration project for pre-paid health care.

It is critical that sufficient information be submitted with requests for cost-effectiveness review. Determinations are based on medical needs as well as premium expenses; adequate information is required to make an accurate assessment

Indemnity Insurance Policies

Indemnity insurance policies are not considered HI policies; premium payments may not be paid out of MA funds nor may they be used to meet a spenddown. These policies should not be referred for review of cost-effectiveness.

Medicare Prepayment Plans

Medicare prepayment plans which have contracts with the Federal Government to provide HMO services to Medicare beneficiaries, require cost-effectiveness review by benefit recovery section. Changes in the premiums and benefits available under these plans now necessitate review.

Long Term Care Clients

Whenever a recipient resides in a long term care facility and has medical insurance which is determined to be cost effective, the premium shall be paid out of the MA assistance account and not from client income.

Client Spenddown

In a case where there is a 6-month spend down, the premium for medical insurance may be considered as part of the recipient's spenddown amount or the premium may be paid out of the MA assistance account for months that the recipient is eligible.

Recipient Reimbursement for Premium Payment

When an applicant is found eligible for MA and has paid for cost effective medical insurance premiums during the month of application and retroactive eligibility period, the recipient shall be reimbursed for the amount s/he paid for those premiums if:

(a) the applicant/recipient was eligible for MA during the retro months;

(b) the premiums were paid for cost-effective health insurance; and

(c) the premiums were not used to satisfy a spenddown or as an employment expense.

If a part of a premium is used to satisfy a spenddown requirement, then the reimbursement must reflect only the portion of the premium which was not used to satisfy the spenddown.

If the entire family is not eligible for MA, but the premium coverage is for all family members, the reimbursement must reflect only the costs for the eligible family members. A breakdown of the premium amount for the eligible family members should be obtained. If that is not available, the premium amount should be prorated according to the number of covered persons.

Medicare Part A Premiums

Some individuals age 65 or older do not meet the requirements for premium-free hospital insurance under Medicare Part A. Persons who lack the quarters of coverage for entitlement to Part A or persons not enrolling when they become eligible for Part A, are required to pay a monthly premium for coverage.

Part A premiums are payable out of the MA account. Cost-effectiveness review is not required.

Persons not enrolling timely for Part A may be charged a 10 percent penalty for each 12-month period of non-enrollment. Effective July 1, 1986, the late enrollment premium is limited to 20 percent above the monthly premium. Federal Financial Participation (FFP) for the premium payment is available at the Federal Medical Assistance Percentage (FMAP) rate rather than at the administrative rate.

The local agency should make payment from the "Medicare Payment Due Notice" received by the recipient each month. The check is made payable and sent to HCFA Medicare Insurance, Medicare Premium Collection Center, Department 98081, Louisville, Kentucky 40298.

Medicare Part B Premiums

Medicare Part B premiums may not be paid out of MA funds for persons not entitled to SSI or Minnesota Supplemental Aid (MSA) benefits. Persons receiving SSI or MSA and MA who are eligible for Medicare Part B, will be covered under the State Buy-In Program referenced in section IV-D.

Medicare and Prepayment Plans

Persons covered by Medicare Part B are eligible to enroll in Medicare Prepayment Plans. Medicare Prepayment Plans include Health Maintenance Organizations (HMO) and Competitive Medical Plans (CMP) that have contracts with the Federal Government to provide services to Medicare beneficiaries. The premium paid to the prepayment plan is for deductibles and coinsurance, and for benefits in addition to those covered by Medicare. It is not the premium for Medicare Part B medical insurance.

Some prepayment plans will not pay for services outside the plan system; these denied services do not qualify for MA reimbursement.

The HI cost-effectiveness review by the benefit recovery section is required for Medicare prepayment plans. Premiums may be paid from MA funds for those Medicare covered persons when cost-effectiveness has been established.

NEW YORK

Section II - TPL Practice D-1 of this Guide contains the automated process used by New York for determining cost benefits relating to the continuation of coverage for Medicaid recipients. New York has also developed the cost of providing medical services for each program category of Medicaid recipients for comparison purposes in evaluating the cost-effectiveness of paying insurance premiums.

NEW YORK STATUTE

Group Health Insurance Benefits: Conditions of Eligibility

Notwithstanding any other inconsistent provision of law and to the extent permissible under Federal law, any applicant for or recipient of home relief or aid to dependent children who is or becomes employed and whose employer provides group health insurance benefits, including benefits for a spouse and dependent children of such applicant or recipient, shall apply for and utilize such benefits as a condition of eligibility for home relief or aid to dependent children.

Such applicant or recipient shall also utilize such benefits provided by former employers as long as such benefits are available. The Department shall promulgate regulations to determine the eligibility requirements of those applicants and recipients who have more than one employer offering group health insurance benefits.

The provisions of this section shall apply to such applicants upon their initial certification for aid to dependent children or home relief and to such recipients upon their recertification for such assistance following the date on which this section becomes effective. The cost of premiums paid by such applicants or recipients for such coverage shall be deducted from such applicant's or recipient's earnings as an expense incident to his employment, in addition to any other expenses allowed pursuant to the provisions of section 131-1 of this article.

WASHINGTON

During July 1989, Washington State commenced purchasing health insurance for medical assistance recipients. Washington State Law allows for payment of insurance premiums when it is cost-effective to do so. Premium payments involve private HI, group plans, Medicare supplemental plans, and others, and include those persons failing under the extension provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA).

MMIS reports are generated every 6 months which provide actual medical service expenditures for recipients by age and sex categories. These reports are used together with the cost of premiums and State staff costs to determine the cost effectiveness for the continuation of providing medical coverage to these recipients through this unique practice.

For those AIDS patients not on assistance, State funds are used to purchase insurance, thus reducing the rate of reduction of income used for medical care. This results in adequate medical expenditure support without expenditures.

For any individuals with AIDS, actual program expenditures are monitored to maintain cost-effective administration and premium payments. Since FY 86, on-going costs for individuals diagnosed with AIDS has continued to decline.

Average monthly expenditures are as follows:

FY 86 $2,056; FY 87 $2,077; FY 88 $1,815; FY 89 $1,931; FY 90 (incomplete $1,238).

These declines are associated with: (1) improved use of drugs in treatment, (2) hospice and less costly primary care delivery, and (3) the effect of health insurance purchases.

Legislation regarding both public assistance individuals and State only Class IV AIDS individuals are as follows:

NEW SECTION §213. FOR THE DEPARTMENT OF SOCIAL AND HEALTH SERVICES - MEDICAL ASSISTANCE PROGRAM

(1) The Department is authorized under 42 USC §1396(a)(1) to pay third-party health insurance premiums for categorically needy medical assistance recipients upon a determination that payment of the health insurance premium is cost effective. In determining cost effectiveness, the Department shall compare the amount, duration, and scope of coverage offered under the medical assistance program.

NEW SECTION §3. A NEW SECTION IS ADDED TO CHAPTER 70.24 RCW TO READ AS FOLLOWS:

(1) "Class IV Human Immunodeficiency Virus Insurance Program", as used in this section, means the program financed by State funds to assure health insurance coverage for individuals with Class IV human immunodeficiency virus infection, as defined by the State Board of Health, who meet eligibility requirements established by the Department.

(2) The Department may pay for health insurance coverage with funds appropriated for this purpose on behalf of persons who are infected with Class IV human immunodeficiency virus, meet program eligibility requirements, and are eligible for "continuation coverage" as provided by the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 or group health insurance policies: PROVIDED, that this authorization to pay for health insurance shall cease on June 30, 1991, as to any coverage not initiated prior to that date. NOTE: Extension will be requested by State agency.

SECTION I - TPL PRACTICE D-4

Third Party Information Reported Via the Electronic Medicaid Eligibility Verification System (EMEVS) *** NEW YORK**

1. Abstract - In January 1987, New York State implemented the Electronic Medicaid Eligibility Verification System (EMEVS). This system is used by providers to verify recipient eligibility prior to provision of Medicaid services. A recipient must present an official Medicaid identification card to the provider when requesting services. The verification process through EMEVS is used to determine the recipient's eligibility for Medicaid services and supplies. A provider not verifying eligibility prior to provision of services risks the possibility of nonpayment for those services.

   The verification process through EMEVS is completed using one of two possible methods, the Medicaid Eligiblity Terminal (MET) or a telephone verification process using an audio response unit (ARU). Verifications can be completed within seconds through the use of a touch-tone telephone, a rotary telephone with a tone generator, a tone generator handset, or a MET terminal.

   Following is the information available through EMEVS:

   - The eligibility status of a Medicaid recipient for a specific date,

   - the county having financial responsibility for the recipient (used to determine the contract office for prior approval and prior authorization),

   - any Medicare or third party insurance coverage that a recipient may currently have or had for the date in inquiry, including HMO coverage.

   The specific third party data that is provided for the date of service entered includes:

   - Medicare Parts A & B,
   - HI claim number,
   - insurance company code, and
   - services covered by insurance carrier.

2. Impact of Practice

2.1 Affected Segment of Caseload:

This impacts every Medicaid eligible recipient in the State.

2.2 Savings:

The Third Party Resources portion of the EMEVS is used to alert providers to recipient insurance and Medicare coverage. This information was previously made available to providers on a paper Medicaid ID card. Therefore, the implementation of this system has not created additional savings. The EMEVS is one part of a group of automated efforts used to reduce Medicaid expenditures through the utilization of recipient HI and Medicare.

2.3 Other Benefits:

Explained in Part 1 Abstract

3. Ongoing Operational Annualized Cost

Minimal

4. Implementation Costs/Times

There was very little cost for implementation because the TPR portion of EMEVS represents one small aspect of the entire system. Implementation proceeded from January 1987 to May 1987.

TPL Identification Through the Automated Intake System (AIS) *** ILLINOIS**

1. <u>Abstract</u> - The Department's model Automated Intake System (AIS) ensures that intake eligibility workers inquire about Medicare enrollment, TPL coverage, personal injury and information regarding real property and assets which may affect the Department's claim against the estate of a deceased recipient. A positive response to questions on generic screens brings up expanded screens to capture more detailed information and prompt the eligibility worker to complete referral forms.

2. <u>Impact of Practice</u>

   2.1 Affected Segment of Caseload:

   This practice impacts on all Medicaid applicants whose intake eligbility interviews are conducted at the local office.

   2.1 Savings:

   Actual amount of savings is unknown, but TPL identification has increased.

3. <u>Operational Annualized Cost</u>

   The cost is absorbed in entire AIS operational costs.

4. <u>Implementation Cost/Time</u>

   Unknown.

Use of the Attorney General's Office in Collection of Medicaid Recoverable Dollars * IDAHO

1. Abstract - In cases where a recipient is injured, has decided to file suit against the injuring party, and has retained an attorney, the third party unit involves the Attorney General's office.

   When the Third Party Unit receives a claim with an injury diagnosis, a questionnaire is sent to the recipient. One question on this form requests litigation information and states;

   "Do you plan to bring legal action against anyone for your accident?"

   "If so, please give the name, address and phone number of your attorney."

   As soon as the Third Party Unit is aware that a recipient is filing suit, the information we have obtained is referred to the Attorney General's office.

   When the Attorney General's office receives a referral from the third party unit, they will immediately contact the recipient's attorney and file a lien on the settlement. When a settlement is acquired, Medicaid is the first to be repaid (after the attorney) and we are then able to recover some or all of the medical expenses we have paid. From this point on, all contact with the recipients attorney is handled by the Attorney General's office. However, the Attorney General cannot compromise or approve a settlement without Department of Health and Welfare's approval.

   The Attorney General's office has a para-legal on staff and an attorney whose time is almost entirely dedicated to third party related issues.

2. Impact of Practice

   2.1 Affected Segment of Caseload:

   This practice has potential impact on the entire Medicaid population.

2.2 Savings:

$104,159 79 Cases (Avg. Per Case $1,320)

2.3 Other Benefits:

One of the major benefits we have achieved is the legal input and the assurance that all legal guidelines and time limits are met.

3. Ongoing, Operational, Annualized Costs

None - The Attorney General and staff are always available for the use of any Health and Welfare Department. We are simply taking advantage of this service.

4. Implementation Costs/Times

Minimal

SECTION I - TPL PRACTICE D-7

TEFRA Liens *** MARYLAND**

1. Abstract - The Maryland Medical Assistance Program implemented regulations to allow placement of a lien against the property of an institutionalized Medical Assistance recipient determined medically unable to return to his home in the community, pursuant to the provisions of TEFRA.

2. Impact of Practice

   2.1 **Affected Segment of Caseload:**

   This practice impacts any Medical Assistance recipient who owns real property, is a patient in a long term care facility, has been determined medically to have no reasonable expectation for discharge from the facility and return home, and whose home is not the current lawful residence of the person's spouse, child, disabled son or daughter, or sibling who meets certain tests concerning interest and continuous residence.

   2.2 **Savings (Recoveries):**

   Maryland recovered $300,000 from TEFRA liens in FY 89.

   2.3 **Other Benefits:**

   The prime benefit of implementing this procedure is the maintenance of Medical Assistance eligibility for long term care facility residents who would otherwise be ineligible because the value of their non-excludable home in conjunction with other resources would exceed the resource limit for eligibility. By permitting a lien to be filed on their realty, they can secure continued care.

   The State protects itself with the placement of the lien, which constitutes a claim against the proceeds of sale of the property. When the sale occurs, the lien must be satisfied before title can pass from seller to buyer. In an estate sale, this gives settlement of the lien preference even over the preferred creditors of the estate.

3. Ongoing Operational Cost (Annualized)

There are no staff costs directly attributable to this practice because it was implemented with existing TPL staff. Court costs for filing original liens and semiannual updates in the property records are less than $10,000 annually and are reimbursed at time of settlement. Medical determination of inability to return to the home in the community is made by a peer review organization. Because this is an adjunct activity to the determination of medical eligibility for long term care, there is no cost for this activity.

4. Implementation Costs/Time

Implementation costs included printing and distribution of regulations, procedures and forms to local departments of social services and training of eligibility technicians in the new procedures. TPL Division-specific costs were minimal, being restricted to the salary of the Division's Special Counsel for the time spent in meeting with court custodians of property records to formalize the lien filing process.

The lien provisions were implemented by regulation rather than legislation.

The implementation period was 18 months, including the drafting and issuing of the regulations.

SECTION I - TPL PRACTICE D-8

Use of a Contingency-Fee Contractor for TPL Identification/Recovery *** ALASKA**

1. Abstract - During April 1986, Alaska was made aware of additional staffing reductions which would occur in the State Medicaid Program, effective July 1, 1986. This would leave one-half a full-time equivalent (FTE) to perform the TPL functions.

State and Federal staff met and discussed the possibility of developing a Request for Proposal (RFP) for the purpose of selecting a contingency fee contractor to perform all the facets of third party. HCFA's Transmittal Number 42 to the State Medicaid Manual dated August 1986, paved the way for this to occur.

A one-year contract (with two one-year options to extend) was awarded to Touche Ross and Co. on December 24, 1986, with an effective date of February 2, 1987. The initial contract provided for a 20 percent contingency fee (excluding collections attributable to such Federally-funded programs as Medicare, Veterans Administration, Champus, etc.) until such time as the Contractor recovered his costs. The contingency fee would then be reduced to 8 percent.

There are provisions in the contract requiring the establishment of a joint bank account for receipt and disbursement of collections, the requirement for Touche Ross and Co. to submit detailed quarterly progress reports and for their cost reports to be audited on an annual basis. The Medicaid State Agency assists the Contractor, when required, and monitors the contractor's performance.

Touche Ross and Co. designed developed and implemented an "Alaska TPL System" in approximately thirty (30) days which was fully operational by the effective date of the contract. The State has proprietary rights to the system which contains four major data bases and is still in use. At the onset, the Contractor prepared articles for the major newspapers in Alaska and wrote letters to the Medicaid providers advising they would handle all facets of TPL and would be acting in the capacity as an agent of the State.

2. Impact of Practices

2.1 Affected Segment of Caseload:

The Contractor is responsible for handling all aspects of the TPL Program on behalf of the Division of Medical Assistance, State of Alaska for Medicaid (Title XIX), and the General Relief (GRM)(State) Programs.

The Contractor identifies "new" third party resources, retroactively bills third party resources on newly-developed resources, and performs data matches with the Child Support Enforcement Division (CSED), Workers' Compensation, and private insurers; i.e., Aetna, Blue Cross/Blue Shield, Metropolitan, and Provident. In addition, Touche Ross and Co. is responsible for processing all Trauma Code Reports (TP-6) generated by the Medicaid Management Information System (MMIS) to include providing legal counsel in the settlement of casualty cases. The Contractor also performs hospital audits to detect possible duplicate payments; i.e., a provider is paid by Medicaid and subsequently receives payment from a third party resource.

2.2 Collections/Savings (February 2, 1987 - February 2, 1990):

$2,100,000	(Actual Collections)
695,000	(Annualized Savings due to 253 cost avoidance referrals)
2,300,000	(Pending settlement of casualty cases and a decision involving a major insurance company re: timely filing of claims)

2.3 Other Benefits:

State and Federal funds are not required "up front" as the Contractor is paid a percentage of "hard-dollar" collections. A contingency fee contract provides a real incentive for the Contractor to pursue all third party leads in order to recover Medicaid funds.

One of the major benefits in terms of saving State/Federal dollars occurs due to Touche Ross and Co.'s having two (2) attorneys in Anchorage on their staff who are available for consultation and the handling of casualty cases. These legal services are all part of the contingency fee and there have only been two instances when additional legal fees were paid to these attorneys and those were very complicated, time-consuming cases whereby briefs and court appearances were required.

3. Ongoing, Operational, Annualized Costs

Contingency fee of 20 percent with a reduction to 8 percent when contractor's costs are recovered.

4. Implementation Costs/Times

$400,000 for the initial design, development, and implementation of "Alaska's TPL System."

5. State Specific Features

The period of performance for the initial contingency fee contract was extended through June 30, 1990. It is to be noted that the contract was amended the second year to provide a contingency fee for the collection of third-party dollars from Federal entities as provided for in HCFA's Transmittal Number 55 dated January 1988.

The use of a contingency fee contractor has proven so successful in Alaska that an RFP for a competitive procurement was issued on March 20, 1990, in order to enter into a "new" contract, effective July 1, 1990.

Alaska is currently in the process of awarding a 3 year contract with a provision to extend the period of performance for two additional 1-year periods.

SECTION I - TPL PRACTICE D-9

Coverage of Dependent Children Not Residing in Household of Policyholder

* ILLINOIS
* MINNESOTA
* OREGON

1. Abstract - Insurance companies shall be prohibited from excluding coverage to dependents solely because the dependents do not reside in the same household as the insured.

2. Impact of Practice

   2.1 Affected Segment of Caseload:

   This practice affects dependent children in Medicaid programs.

   2.2 Savings:

Unknown	ILLINOIS
Unknown	MINNESOTA
$8.5 Million[1]	OREGON

[1]Oregon estimates that, without Oregon Revised Statute (ORS) 743.716, children of absent parents would lose their insurance coverage, resulting in an increase of $8.5 million dollars per biennium in Medicaid expenditures.

3. Ongoing, Operational, Annualized Cost

   Unknown

4. Implementation Costs/Times

   Unknown

5. State Specific Features

   ILLINOIS

   Section 356, Public Law 86-649 (HB 2409), which was effective January 1, 1990, follows below.

ILLINOIS STATUTE

Sec. 356h. No individual or group policy of accident and health insurance which covers the insured's immediate family or children, as well as covering the insured, shall exclude a child from coverage or limit coverage for a child solely because the child is an adopted child, or solely because the child does not reside with the insured. For purposes of this Section, a child who is in the custody of the insured, pursuant to an interim court order of adoption vesting temporary care of the child in the insured, is an adopted child, regardless of whether a final order granting adoption is ultimately issued.

Section 7. This Act takes effect on January 1, 1990.

MINNESOTA

Selected portions of Chapter 62, Minnesota Legislation, which addresses dependent coverage issues follows.

MINNESOTA STATUTE

ACCIDENT AND HEALTH INSURANCE

62A.047 DEPENDENT COVERAGE.

A policy of accident and sickness insurance that covers an employee who is a Minnesota resident must, if it provides dependent coverage, allow dependent children who do not reside with the covered employee to be covered on the same basis as if they reside with the covered employee. Neither the amount of support provided by the employee to the dependent child nor the residency of the child may be used as an excluding or limiting factor for coverage or payment for health care.

Note: Section 270 of article 2 in chapter 689 provides that this section applies to any policy plan or contract issued or renewed on or after April 29, 1988.

Also Note: Chapter 571, section 1, also creates a new statute at Minnesota Statute section 62A.047. This conflict should be resolved by the revision of statutes in the official version of Minnesota Statutes.

NONPROFIT HEALTH SERVICES PLAN CORPORATIONS ACT

62C.143 DEPENDENT COVERAGE.

A subscriber contract of a nonprofit health service plan corporation that covers an employee who is a Minnesota resident must, if it provides dependent coverage, allow dependent children who do not reside with the covered employee to be covered on the same basis as if they reside with the covered employee. Neither the amount of support provided by the employee to the dependent child nor the residency of the child may be used as an excluding or limiting factor for coverage or payment for health care.

Note: Section 270 of article 2 in chapter 689 provides that this section applies to any policy plan or contract issued or renewed on or after April 29, 1988.

HEALTH AND MAINTENANCE ACT OF 1973

62D.104 DEPENDENT COVERAGE.

A health maintenance organization subscriber contract must, if it provides dependent coverage, allow dependent children who do not reside with the covered employee to be covered on the same basis as if they reside with the covered employee. Neither the amount of support provided by the employee to the dependent child nor the residency of the child can be used as an excluding or limiting factor for coverage or payment for any health care. Coverage under this section shall apply only if the dependent child resides within the service area of the health maintenance organization of if the dependent child is a birth or legally adopted child.

Note: Section 270 of article 2 in chapter 689 provides that this section applies to any policy plan or contract issued or renewed on or after April 29, 1988.

HEALTH CARE

62E.04 DUTIES OF INSURERS.

Subd. 9. Reduction of benefits because of ERISA service
No plan of health coverage including, but not limited to, a plan under the Federal Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, sections 1001 1461, which covers a Minnesota resident shall deny or reduce benefits because services are rendered to a covered person or dependent who is eligible for receiving benefits under chapter 256B.

Subd. 10. Dependent coverage. A plan of health coverage under the Federal Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, sections 1001 to 1461 which covers an employee who is a Minnesota resident must, if it provides dependent coverage, allow dependent children who are eligible for or receiving benefits under chapter 256B and who do not reside with the covered employee to be covered on the same basis as if they reside with the covered employee. Neither the amount of support provided by the employee to the dependent children nor the residency of the child can be used as an excluding or limiting factor for coverage or payment for any health care.

Note: Section 270 of article 2 in chapter 689 provides that this section applies to any policy plan or contract issued or renewed on or after April 29, 1988.

OREGON

ORS 743.716 is a result of a proposal made to the 1985 legislative session. At that time, a growing number of insurance policies contained provisions which excluded children from being served by Child Support and Medicaid Programs. This practice of excluding dependent children who did not live in the policyholder's home, resulted in a number of children losing their insurance coverage. The Oregon statute appears on the following page.

OREGON REVISED STATUTE

743.716 Coverage of children not residing in household of policyholder or employee of policyholder.

(1) All policies providing health insurance as defined in ORS 731.162 and containing coverage for children of policyholders or children of employees of policyholders shall provide that children not residing in a policyholder's or employee's household shall be eligible for coverage to the same extent as children residing with the employee or policyholder, so long as the policyholder or employee is under a legal obligation to support or contribute to the ongoing support of the children not residing in thehousehold and providing that there is not a court order to the contrary.

(2) Subsection (1) of this section does not require a health maintenance organization as defined in ORS 442.015 to provide coverage for any children of a policyholder or employee who reside outside the service area of the health maintenance organization. (Formerly 743.140)

Medical Insurance Enforcement * OREGON

1. Abstract - 1989 Oregon Laws, Chapter 812, implemented medical insurance enforcement provisions. This law was effective October 3, 1989, and requires the use of wage withholding, when appropriate, to assure that insurance is obtained.

2. Impact of Practice

2.1 Affected Segment of Caseload:

The law is an enforcement tool to assure that absent parents obtains medical and dental insurance for dependent children when it is so ordered and is available.

2.2 Savings:

This is a new practice. There is insufficient experience to determine savings at this time.

2.3 Other Benefits:

These will be established in the future.

3. Ongoing, Operational, Annualized Costs

Unknown

4. Implementations Costs/Times

Unknown

5. State Specific Features

All child support orders require the obligee to name a dependent child as a beneficiary on any health plan that is available to the obligee on a group basis through an employer or union. The obligee or entity responsible for support enforcement may serve a notice of order on the employer or union to provide insurance coverage and request a written acknowledgment or receipt. If the employer or union fails to provide written proof within thirty days of receiving the notice of order that the insurance has been obtained or that the application for insurability has been made, the obligee

or entity responsible for support enforcement serves notice of order of its intent to enforce medical support. The notice of order requiring insurance is binding on the employer or union when service has been effected. The employer or union shall enroll the child as a beneficiary in the group insurance plan and withhold any required premium from the obligor's income or wages. Chapter 812 of 1989 Oregon law is the pertinent legislation which follows.

CHAPTER 812

AN ACT HB 2454

Relating to support; creating new provisions; and amending ORS 25.310, 25.370, 108.120, 109.100, 109.165, 110.022, 110.201 and 416.400.

Be It Enacted by the People of the State of Oregon:

SECTION 1. Sections 2 and 3 of this Act are added to and made a part of ORS chapter 25.

SECTION 2. (1) All child support orders entered pursuant to ORS chapters 107, 108 and 109 and ORS 416.400 to 416.470 and 419.513, and any modifications of those orders, shall provide, at the election of the obligee, assignee of the rights to medical support under the Medicaid program or the assignee of current support rights, that the obligor shall name the subject child as beneficiary on any health and dental insurance plan that is available to the obligor on a group basis or through an employer or union at a cost determined under ORS 416.420 unless the group insurance is not accessible to the child or obligee. The Administrator of the Support Enforcement Division, an administrative hearings officer or a court may reduce the child support obligation determined under ORS 416.420 by all or a portion of the cost of providing health and dental insurance when the obligee, assignee of the rights to medical support under the Medicaid program or the assignee of current support rights has elected such coverage.

(2) In addition to the health and dental insurance coverage required in subsection (1) of this section, the order shall also require the obligor to provide dependent health and dental insurance for the benefit of the obligee if it is available at no additional cost to the obligor and in this case the provisions of this section apply. The remedy provided by this subsection is in addition to and not exclusive of any other remedy provided by law.

(3) The obligee or entity responsible for support enforcement under ORS 25.080 may serve a notice of order to provide for insurance coverage in a form prescribed by the Department of Human Resources on the obligor's employer or union or the employer's or union's registered agent, bookkeeper, accountant, person responsible for payroll or local office manager in the manner prescribed for the service of summons in a civil action, or may be served by any type of mail which requests a return receipt or other written acknowledgment of receipt and is addressed to one of the persons listed in this subsection. Service of the notice may be made when the following conditions are met:

(a) The obligor fails to provide written proof to the obligee or the entity responsible for support enforcement within 30 days of receiving notice of the order that the insurance has been obtained or that application for insurability has been made;

(b) The obligee or the entity responsible for support enforcement serves notice of its intent to enforce medical support on the obligor by mail at the obligor's post-office address; and

(c) The obligor fails within 15 days after the mailing of the notice to provide written proof to the obligee or the entity responsible for support enforcement that the insurance coverage existed as of the date of mailing.

(4) The notice of order requiring insurance coverage is binding on the employer or union when service has been effected. Upon receipt of the notice, or upon application of the obligor pursuant to the notice, the employer or union shall enroll the child as a beneficiary in the group insurance plan and withhold any required premium from the obligor's income or wages. If more than one plan is offered by the employer or union, the child shall be enrolled in the insurance plan in which the obligor is enrolled or, if the obligor is not enrolled, the least costly plan otherwise available.

(5) A child that an obligor is required to cover as a beneficiary pursuant to this section is eligible for insurance coverage as a dependent of the obligor.

(6) The signature of the custodial parent or guardian of the insured dependent is a valid authorization to the insurer for purposes of processing an insurance reimbursement payment to the provider of the medical services. When an order for dependent insurance coverage is in effect and the obligor's employment is terminated, or the insurance coverage is terminated, the insurer shall notify the obligee within 10 days of the termination date with notice of conversion privileges.

(7) When an order for dependent insurance coverage is in effect, the obligor's employer or union shall release to the obligee or the entity responsible for support enforcement, upon request, information on the dependent coverage, including the name of the insurer.

(8) The obligor who fails to maintain the medical or dental insurance for the benefit of the child as ordered shall be liable for any medical or dental expenses incurred from the date of the order.

SECTION 3. (1) For the protection of applicants for and recipients of support enforcement services, the Support Enforcement Division, the district attorney and the Department of Human Resources shall not disclose or use the contents of any records, files, papers or communications for purposes other than those directly connected with the establishment and enforcement of support obligations, including

criminal nonsupport proceedings, and these records, files, papers, and communications are considered confidential. In any judicial proceedings except proceedings directly connected with the establishment or enforcement of a support obligation, including a criminal nonsupport proceeding, their contents are considered privileged communications.

(2) Violation of subsection (1) of this section is punishable, upon conviction, by a fine of not more than $1,000 or by imprisonment in the county jail for not more than 60 days, or by both.

SECTION 4. ORS 25.310 is amended to read:

25.310. (1) In addition to any other remedy provided by law for the enforcement of support, when a support order is or has been issued in Oregon by the circuit court or the administrator, as defined in ORS 416.400, or has been registered in Oregon, and current support payment records are being maintained by the Department of Human Resources, then so much of an obligor's disposable earnings must be withheld in accordance with subsections (2) to (14) of this section as is necessary to comply with the order and provide for the payment of any fee to the employer which may be required. Withholding shall occur without the need for any amendment to the support order involved or for any further action, other than those actions required under this section, by the court or administrator.

(2) An obligor shall become subject to such withholding, and the advance notice required under subsection [(4)] (3) of this section must be given, on the earliest of:

(a) The effective date of a support order or modification of a support order in a case for which support enforcement services are being provided pursuant to ORS 25.080, unless the administrator or court finds that there is good cause not to require immediate withholding or the parties provide by written agreement for an alternative arrangement;

[(a)] (b) The date on which the payments which the obligor has failed to make under such order are at least equal to the support payable for one month; [or]

[(b)] (c) The date as of which the obligor requests that such withholding begin; or [.]

(d) The date on which the obligee requests that such withholding begin, if good cause is shown for the withholding.

(3) The advance notice regarding the delinquency of support payments and potential withholding shall be issued and sent by regular mail by the Department of Human Resources to the last-known address of the obligor. A copy of the notice shall be mailed by the department to the last-known address of the obligee. The advance notice must state:

(a) The amount of arrearages and the amount to be withheld;

(b) That the provision for withholding applies to any current or subsequent employer or period of employment;

(c) The procedures available for contesting the withholding and that the only basis for contesting the withholding is a mistake of fact, which means an error in the amount of current support or arrearages, or an error in the identity of the obligor;

(d) That the obligor has 14 days from the date of the notice to contact the district attorney or the Support Enforcement Division of the Department of Justice, as appropriate, in order to contest the withholding, and that failure to make such contact within 14 days will result in the department notifying the employer to begin withholding; and

(e) The actions that will be taken if the obligor contests the withholding.

(4) Upon request of either the district attorney or the Support Enforcement Division, a new advance notice which increases the amount to be withheld may be issued by the department.

(5) The amount to be withheld shall include any fee to the employer, as defined in ORS 23.175, which the department may establish, and may include arrearages.

(6) If the obligor does not make the contact within the period specified in paragraph (d) of subsection (3) of this section, the department shall immediately send notice to the employer to begin withholding.

(7) If the obligor makes the appropriate contact outlined in paragraph (d) of subsection (3) of this section within the 14-day period, then the district attorney or Support Enforcement Division, as appropriate, shall provide the obligor with an opportunity to show that there is an error in the amount of current support or arrearages, or an error in the identity of the obligor. Payment of all arrearages may not be the sole basis for not implementing withholding. The department shall by rule set additional criteria for not implementing withholding. The district attorney or Support Enforcement Division need not provide an opportunity for a contested case administrative hearing pursuant to ORS 183.310 to 183.550 or a hearing in circuit court. Within 45 days of the date of the advance notice, the district attorney or Support Enforcement Division must determine if the withholding shall occur based on an evaluation of the facts, notify the obligor whether or not the withholding is to occur, notify the obligor of the right to appeal the determination and send the employer's notice with the information required by subsection (9) of this section. If withholding is to occur, the notice to the obligor shall state when withholding will begin and shall include the information given to the employer in the employer's notice.

(8) Any appeal of the district attorney's or Support Enforcement Division's decision made pursuant to subsection (7) of this section is to the circuit court for a hearing de novo. The appeal shall not act to stay withholding without a court order to that effect. No stay or partial stay shall be ordered by any court unless the obligor can show there is a substantial probability that the obligor would suffer

irreparable injury and the obligee would not suffer irreparable injury.

(9) The notice to the employer of the obligor shall inform the employer of all the following:

(a) The employer shall withhold from the obligor's disposable earnings, as defined in ORS 23.175, the amount stated in the notice, subject to the following:

(A) For as long as arrearages are owed, the amount to be withheld shall not be less than 25 percent of the obligor's disposable earnings plus an employer fee or the amount of the monthly support obligation plus $1 plus an employer fee, whichever is greater.

(B) When arrearages are paid in full, the amount to be withheld shall equal the monthly support obligation plus an employer fee.

(C) Notwithstanding subparagraph (A) or (B) of this paragraph, the amount to be withheld shall not exceed the maximum amount permitted under section 303(b) of the Consumer Credit Protection Act (15 U.S.C. §1673(b)) as of January 3, 1985.

(b) Out of the amount withheld, the employer may deduct an employer fee as stated in the notice, or the employer may waive the fee. If an employer waives the fee, the amount to be withheld under subparagraph (A) or (B) of paragraph (a) of this subsection shall not include an employer fee.

(c) Payments of the amount withheld, less any employer fee, shall be identified and made to the department within 10 days of the date the obligor is paid.

(d) The employer shall implement withholding no later than the first payday that occurs after five days following the date the notice was received.

(e) The withholding required by this notice is a continuing obligation. This notice and the withholding required by it remain in effect and are binding upon the employer until further notice from the department or a court.

(f) The employer is liable for all amounts which the employer fails to withhold and pay to the department pursuant to this section. Upon motion to the court by the district attorney or Support Enforcement Division, the court may also fine the employer in an amount not to exceed $250 for a violation of this paragraph.

(g) The employer shall not inquire about the existence of a support or withholding obligation and shall not discharge, discipline or refuse to hire an obligor because of the existence of a withholding obligation under this section. Upon motion by the district attorney or Support Enforcement Division, the court may also fine the employer for a violation of this paragraph in an amount not to exceed $250.

(h) Withholding under this section has priority over any other legal process under Oregon law against the same income.

(i) The employer may combine amounts from obligors' incomes in a single payment to the department, as long as such payment is accompanied by a list which separately identifies which portion of the payment is attributable to each obligor and the obligor's name and case number.

(j) If there is more than one notice requiring withholding against a single obligor under this section, the employer shall honor all withholdings to the extent that the total amount withheld from the obligor's income does not exceed the limits imposed under section 303(b) of the Consumer Credit Protection Act (15 U.S.C. §1673(b)) as of January 3, 1985. If the obligor's income is not sufficient to fully comply with multiple notices requiring withholding, the distribution of the withholding by the department shall be conducted pursuant to the department's rules.

(k) The employer shall notify the department promptly when the obligor terminates employment, and shall provide the obligor's last-known address and the name and address of the obligor's new employer, if known.

(10) The employer is bound by and required to follow the notice and its provisions as set out in subsection (9) of this section. Failure to comply with the notice subjects the employer to the consequences set out in subsection (9) of this section.

(11) Withholding under this section has priority over any other legal process under Oregon law against the same income.

(12) Withholding under this section may not be terminated solely because all arrearages are paid. Withholding may be terminated if all arrearages are paid and:

(a) The duty to support under the support order no longer exists; or

(b) The obligor and obligee request termination in writing and public assistance is not being granted to either party, their minor dependents or their children who are attending school, as defined in ORS 107.108.

(13) The employer's notice may be personally served upon the employer or the employer's registered agent, bookkeeper, accountant, person responsible for payroll or local manager or may be served by any type of mail which requests a return receipt or other written acknowledgment of receipt and is addressed to one of the persons listed in this subsection.

(14) No employer who complies with an employer's notice issued pursuant to this section shall be liable to the obligor or to any other person claiming rights derived from the obligor for wrongful withholding.

SECTION 5. ORS 25.370 is amended to read:

25.370. Any child support order issued or modified after October 1, [1985] 1989, shall include a statement in substantially the following form:

NOTICE OF INCOME WITHHOLDING

The support order is enforceable by income withholding under ORS 25.310. Withholding may occur immediately, whenever there are arrearages at least equal to the support payment for one month,

[*or*] whenever the obligated parent requests such withholding or whenever the obligee requests withholding for good cause. The district attorney or, as appropriate, the Support Enforcement Division of the Department of Justice will assist [*you*] in securing such withholding.

SECTION 6. ORS 108.120 is amended to read:

108.120. (1) After the hearing of the petition for an order of support the court shall make an order granting or denying it and fixing, if allowed, the terms and amount of the support.

(2) The court has the same power to compel the attendance of witnesses or the production of testimony as in actions and suits, to make such decree or orders as are equitable in view of the circumstances of both parties and to punish violations thereof as other contempts are punished.

(3) The decree or order is a final judgment as to any instalment or payment of money which has accrued up to the time either party makes a motion to set aside, alter or modify the decree or order, and the court does not have the power to set aside, alter or modify such decree or order, or any portion thereof, which provides for any payment of money, either for minor children or the support of a party, which has accrued prior to the filing of such motion. However, the court may allow a credit against child support arrearages for periods of time, excluding reasonable visitation unless otherwise provided by order or decree, during which the obligated parent has physical custody of the child with the knowledge and consent of the custodial parent.

SECTION 7. ORS 109.100 is amended to read:

109.100. (1) Any minor child or state agency on behalf of that minor child may, in accordance with ORCP 27 A., apply to the circuit court in the county in which the child resides, or in which the natural or adoptive father or mother of the child may be found, for an order upon such child's father or mother, or both, to provide for the child's support. The minor child or state agency may apply for the order by filing in such county a petition setting forth the facts and circumstances relied upon for such order. If satisfied that a just cause exists, the court shall direct that the father or mother appear at a time set by the court to show cause why an order of support should not be entered in the matter. If it appears to the satisfaction of the court that such child is without funds to employ counsel, the court may make an order directing the district attorney to prepare such petition and order to show cause.

(2) The order is a final judgment as to any instalment or payment of money which has accrued up to the time either party makes a motion to set aside, alter or modify the order, and the court does not have the power to set aside, alter or modify such order, or any portion thereof, which provides for any payment of money which has accrued prior to the filing of such motion.

[*(2)*] (3) The provisions of ORS 108.110 (3), 108.120 and 108.130 shall apply to proceedings under subsection (1) of this section.

SECTION 8. ORS 109.165 is amended to read:

109.165. Upon motion of either party the court may set aside, alter or modify so much of the decree as may provide for the support of the minor child or child attending school. As to any instalment or payment of money which has accrued up to the time either party files a motion to set aside, alter or modify the decree, the decree is final and the court does not have power to change it. However, the court may allow a credit against child support arrearages for periods of time, excluding reasonable visitation unless otherwise provided by order or decree, during which the obligated parent has physical custody of the child with the knowledge and consent of the custodial parent. A child attending school is a party for purposes of this section.

SECTION 9. ORS 110.022 is amended to read:

110.022. (1) "Court" means the circuit court of this state and when the context requires means the court of any other state as defined in a substantially similar reciprocal law.

(2) "District attorney" means the public official in the appropriate place who has the duty to enforce criminal laws relating to the failure to provide for the support of any person.

(3) "Duty of support" means a duty of support whether imposed or imposable by law or by order, decree, or judgment of any court, whether interlocutory or final or whether incidental to a proceeding for dissolution, separation, separate maintenance, or otherwise and includes, but is not limited to, the duty to provide medical and dental insurance coverage, the duty to pay arrearages of support past due and unpaid and the duty to pay support for a "child attending school" as defined in ORS 107.108 (4) where the other jurisdiction imposes the same or substantially similar duty of support.

(4) "Governor" includes any person performing the functions of Governor or the executive authority of any state covered by this chapter.

(5) "Initiating state" means a state in which a proceeding pursuant to this or a substantially similar reciprocal law is commenced. "Initiating court" means the court in which a proceeding is commenced.

(6) "Law" includes both common and statutory law.

(7) "Obligee" means a person including a state or political subdivision to whom a duty of support is owed or a person including a state or political subdivision that has commenced a proceeding for enforcement of an alleged duty of support or for registration of a support order. It is immaterial if

the person to whom a duty of support is owed is a recipient of public assistance.

(8) "Obligor" means any person owing a duty of support or against whom a proceeding for the enforcement of a duty of support or registration of a support order is commenced.

(9) "Registering court" means any court of this state in which a support order of a rendering state is registered.

(10) "Rendering state" means a state in which the court has issued a support order for which registration is sought or granted in the court of another state.

(11) "Responding state" means a state in which any responsive proceeding pursuant to the proceeding in the initiating state is commenced. "Responding court" means the court in which the responsive proceeding is commenced.

(12) "State" includes a state, territory, or possession of the United States, the District of Columbia, the Commonwealth of Puerto Rico, and any foreign jurisdiction in which this or a substantially similar reciprocal law is in effect.

(13) "Support order" means any judgment, decree, or order of support in favor of an obligee whether temporary or final, or subject to modification, revocation, or remission, regardless of the kind of action or proceeding in which it is entered.

SECTION 10. ORS 110.201 is amended to read:

110.201. (1) If the responding court finds a duty of support, it may order the obligor to furnish support or reimbursement therefor and subject the property of the obligor to such order.

(2) The decree or order is a final judgment as to any instalment or payment of money which has accrued up to the time either party makes a motion to set aside, alter or modify the decree or order, and the court does not have the power to set aside, alter or modify such decree or order, or any portion thereof, which provides for any payment of money, either for minor children or the support of a party, which has accrued prior to the filing of such motion. However, the court may allow a credit against child support arrearages for periods of time, excluding reasonable visitation unless otherwise provided by order or decree, during which the obligated parent has physical custody of the child with the knowledge and consent of the custodial parent.

SECTION 11. ORS 416.400 is amended to read:

416.400. As used in ORS 416.400 to 416.470, unless the context requires otherwise:

(1) "Administrator" means either the Administrator of the Support Enforcement Division, Department of Justice, or the district attorney or the administrator's or the district attorney's authorized representative.

(2) "Court" shall mean any circuit court of this state and any court in another state having jurisdiction to determine the liability of persons for the support of another person.

(3) "Court order" means any judgment, decree or order of any Oregon court which orders payment of a set or determinable amount of support money.

(4) "Debt" means the amount of money owed as child support pursuant to an Oregon court order or an order entered by the administrator under ORS 416.400 to 416.470.

(5) "Department" means the Department of Human Resources of this state or its equivalent in any other state from which a written request for establishment or enforcement of a support obligation is received under ORS 416.475.

(6) "Dependent child" means any person under the age of 18 who is not otherwise emancipated, self-supporting, married or a member of the Armed Forces of the United States. It also means any unmarried person between the ages of 18 and 21 who is not otherwise emancipated and who is a student regularly attending a course of vocational or technical training designed to train that person for gainful employment.

(7) "Director" means the Director of the Department of Human Resources or the director's authorized representative.

(8) "Division" means the Support Enforcement Division of the Department of Justice.

(9) "Office" means the office of the Support Enforcement Division or the office of the district attorney.

(10) "Parent" means the natural or adoptive father or mother of a dependent child. "Parent" also means stepparent when such person has an obligation to support a dependent child pursuant to ORS 109.053.

(11) "Public assistance" means any money payments made by the department which are paid to or for the benefit of any dependent child, including but not limited to payments made so that food, shelter, medical care, clothing, transportation or other necessary goods, services or items may be provided, and payments made in compensation for the provision of such necessities.

Approved by the Governor July 25, 1989
Filed in the office of Secretary of State July 26, 1989

Authorization for State Agency to Enroll Dependents on Absent Parent Employer Related Insurance Policy

* ILLINOIS
* UTAH

1. Abstract - The purpose of this practice is to establish an efficient and effective means of enforcing medical support obligations. If an absent parent has been ordered to maintain insurance for his dependent children, he has 30 days from the date of the order to do so. If he fails to do so on a timely basis as required, a notice to enroll is served on the parent's employer. The employer is obligated to enroll dependent children in a health plan and deduct premiums from the absent parent's paycheck.

2. Impact of Practice

2.1 Affected Segment of Caseload

This practice affects dependent children in Medicaid programs.

2.2 Savings

New legislation in both States.

3. Ongoing, Operational, Annualized Cost

New legislation in both States.

4. Implementation Costs/Times

New legislation in both States.

5. State Specific Features

ILLINOIS

Effective January 1, 1990, Public Act 86-649 (HB 2409) provided that children receive the medical support they rightfully deserve, whenever possible. Employers of absent relatives are ordered as part of income withholding orders to add dependent children to the employee's group health insurance plan. The employer must withhold insurance premiums from the employee's salary in addition to the child support payments withheld.

If an absent relative does not have a group insurance plan available through an employer, the judge will consider ordering the relative to obtain an independent health insurance plan/policy through a group other than an employer (e.g., union, veterans' association) or through a private insurance carrier.

The employer must notify the Department when the employee terminates employment. If available, the employer provides a new home address, name and address of the new employer and other information necessary to proceed withholding. If health insurance is terminated or changed for any reason (e.g., coverage), the employer must notify the custodial parent and the Department of the change and any conversion privileges within 10 days of the change date.

Relatives who are ordered to provide independent health coverage are required to notify the Department within 30 days verifying that the coverage is being provided. The Department will notify the custodial parent of the available coverage and how to use it in conjunction with the medical card. If the relative fails to provide the information as ordered, the relative is responsible for the amount of the unpaid premiums and the medical expenses incurred by dependent children which could have been paid by the health insurance which was ordered.

A copy of the legislation is available upon request from the State.

UTAH

In accordance with Utah's Administrative Procedures Act, the Office of Recovery Services may commence an adjudicative proceeding to determine whether or not to require by order the enrollment of a dependent child in an insurance program that is available through his/her parent or legal guardian's employer or union, when the following conditions are present: The parent or legal guardian is already required to obtain insurance coverage for the child by a prior court or administrative order; the parent or legal guardian has failed to provide written proof to the Office that the child has been enrolled in an insurance plan in accordance with the court or administrative order; or the coverage required by the order was not available at a reasonable

cost thirty or more days prior to the date of the mailing of the notice of agency action. If the Office issues an order to enroll a dependent child in an insurance program, the Office may serve notice of the order on all existing and future employers or unions of the parent or guardian.

As soon as the insurance enrollment period opens, an employer or union shall comply with an order to enroll which is issued by the Office of Recovery Services in accordance with the above procedures.

A copy of the legislation is available upon request from the State.

SECTION II

STATE SUCCESSFUL PRACTICES UNDER DEVELOPMENT

PART A

Implementation of Cost Avoidance Method of Claims Payment and Cost Avoidance Practices

NO SUBMISSIONS

SECTION II

STATE SUCCESSFUL PRACTICES UNDER DEVELOPMENT

PART B

Recovery Practices

Section II - TPL PRACTICE B-1

Medicaid Recovery from Non-Custodial Parents Ordered to Provide Medical Coverage

* MISSOURI

1. Abstract - Division of Child Support Enforcement (DCSE), through the use of administrative process, enters an order for State debt-medical assistance. Once the order is entered, the amount of Medicaid expenditures paid on behalf of the child since the date the non-custodial parent was ordered to provide coverage are recoverable through the same means as child support arrearages. Collection action is suspended if the non-custodial parent provides proof of insurance coverage for the child(ren) in the initial stage.

2. Impact of Practice

   2.1 Affected Segment of Caseload:

   This practice allows recovery of Medicaid expenditures on behalf of children receiving Medicaid benefits whose non-custodial parents have not complied with medical support court orders. Some of these children, as a result of this action, will be covered under a health plan/insurance policy.

   2.2 Savings:

   Unknown

3. Ongoing Operational, Annualized Cost

   Unknown

4. Implementation Costs/Times

   Pilot project implementation has taken approximately three months. Implementation in other DCSE offices will take less time now that the project has been finalized.

5. State Specific Features

A monthly listing of IV-D cases for which Medicaid has incurred expenditures is provided to the DCSE office indicating non-custodial parents which have been order to provide medical insurance coverage and records reflect no known health insurance exists. The office determines if the non-custodial parent is employed, or has resources. A Notice and Finding of Financial Responsibility is issued to the non-custodial parent either by mail or by process server.

The non-custodial parent can respond, and: 1) provide proof of medical insurance coverage for the children, and collection will be suspended for as long as the coverage remains in effect; 2) agree to repay the debt and sign a Consent Order; 3) provide proof that he is disabled and unable to provide such coverage; or, 4) request an administrative hearing. The non-custodial parent can also choose not to respond; cases are defaulted, and the order is then entered for the State debt-medical assistance with the circuit court.

The project started in the pilot offices in March, 1990. It will be expanded throughout the State during the remainder of the State Fiscal Year 1990 and early State Fiscal Year 1991.

Computation of Insurance Benefits Based on Billed Charges

* CONNECTICUT

1. Abstract: - Recoveries of subrogation claims billed by the State to private insurance carriers were being paid at 80 percent of the Medicaid rate rather than 80 percent of the private rate. This resulted in a potential underpayment to the State by the carriers. By citing its power under the Social Security Act to determine the legal liability of third parties to pay claims, the State revised its subrogation notice to include specific billing instructions whereby the carrier computes their full legal liability to pay claims based upon either the providers usual and customary fee or the carriers maximum allowable fee for this service. Once computed, the carrier is instructed to pay the lesser of the Medicaid payments or the computed payment.

2. Impact of Practice

   2.1 Affected Segment of Caseload:

   This practice has potential impact on the entire case universe.

   2.2 Savings:

   Too new to determine

   2.3 Other Benefits:

   In addition to increasing recoveries, it has the effect of ensuring Medicaid recovers only the amount to which it is entitled by State law. This reduces administrative cost of disbursing any overpayments.

3. Ongoing, Operational, Annualized Cost

   Negligible

4. Implementation Costs/Times

   Negligible 2 Months

5. State Specific Features

   Note that the billing information sent to carriers must include both the Medicaid paid amount and the provider's billed charges.

SECTION II

STATE SUCCESSFUL PRACTICES UNDER DEVELOPMENT

PART C

Identification of Resources

TPL Identification Through Crossmatch With the Beneficiary Earnings Exchange Record (BEERS) Data Exchange

* ILLINOIS

1. Abstract - This crossmatch was first conducted as a pilot project in FY 88. SSA pension files (BEERS) were matched with active Aid to the Aged, Blind, and Disabled (AABD) grant and "medical only" cases.

   A letter requesting TPL information was mailed to the pension source to determine if the pensioner was covered by a health insurance plan through that source. Positive responses were added to the TPL data base.

   This crossmatch will be conducted on a monthly basis beginning in late FY 90.

2. Impact of Practice

   2.1 Affected Segment of Caseload:

   This practice has impact on all AABD grant and medical only cases when the individual is identified as a pensioner on the BEER Data Exchange. The FY 88 crossmatch identified 600 individuals who met the above criteria.

   2.2 Savings:

   Total annual savings from the FY 88 crossmatch - $11,232. Of 600 letters mailed, 39 responses were received which identified new TPL (7 percent).

   Total annual savings anticipated from the FY 90 crossmatch have not yet been projected.

3. Ongoing, Operational, Annualized Cost

   Minimal

4. Implementation Costs/Time

   Minimal

Medical Support/Employer's Verification of Dependent Coverage

* ILLINOIS

1. Abstract - Court orders which include a medical support requirement are followed up through the employer to determine if the absent parent has included dependent children for health coverage. If the absent parent has failed to do so, the information is shared with the Child Support Enforcement Agency for enforcement action.

2. Impact of Practice

   2.1 Affected Segment of Caseload:

   This practice affects dependent children in Medicaid programs.

   2.2 Savings:

   To be determined

3. Ongoing, Operational, Annualized Cost

   To be determined

4. Implementation Costs/Times

   To be determined

SECTION II - TPL PRACTICE C-3

Verified TPL Detection Through Wage Clearances

* CONNECTICUT

1. Abstract - Every eligibility and support investigator does a wage clearance to verify reported and/or to detect unreported income. While they always can understand and pursue cash resources, experience has shown that these personnel are less able to understand and accurately interpret Third Party Resources--especially cost avoidance encoding. To facilitate this process, Connecticut proposes to link the wage clearance process with a verified employer health insurance database maintained by TPL staff. As the individual's wage clearance is verified, the Federal Tax Employers Identification Number (EIN) is obtained. This number is used to interrogate the Medicaid's employer file which has been indexed by the Federal Tax EIN. The information contained in Medicaid's file is: each policy an employer offers including verified coding by Medicaid's coverage, deductibles, co-insurance, etc., and employer's policy expiration date. When a wage match is obtained, the verified employer health insurance information is added to the wage clearance and returned to the eligibility/support worker. The worker now has both verified wage and health insurance data. The only tasks for the worker to do are: 1) If multiple employer policies, ascertain which one was selected by the recipient/absent parent; 2) find out who in the case has the coverage; and, 3) find the start dates for any individuals. With these additional items of information, the worker can automatically transmit verified information to the TPL file. Additionally, using the policy expiration date, Medicaid can automatically followup on the policy's termination or renewal.

2. Impact of Practice

   2.1 Affected Segment of Caseload:

   The purpose of this proposal is to link two existing processes, enabling verified health insurance information to be detected and entered on the TPL file.

   This proposal is also useable by IV-D staff.

   2.2 Savings:

   Not available as of publication date

3. Ongoing, Operational, Annualized Cost

To be determined

4. Implementation Costs/Times

To be determined

5. State Specific Features

To build Medicaid's employer file, Connecticut plans to send questionnaires to all employers in the State requesting data on all health insurance policies offered to employees and their dependents. The questionnaires will provide information such as insurance carrier, types of policy coverage, group number specific to that employer (if applicable), and effective dates of employers policy coverage. (Note--Some States already have this file).

Upon receipt, the information will be entered into the Department's Eligibility Management System (EMS). Thus, the eligibility worker will find on a single EMS screen; wages (by individual and by employer), and health insurance benefits (by employer). By verifying wages, the eligibility worker can also identify potential TPL for the individual and his/her dependents. This system will also be shared with the IV-D agency.

SECTION II - TPL PRACTICE C-4

Implementation of Motor Vehicle Accident Data Match *** OREGON**

1. Abstract - Federal regulations published on February 27, 1987, requires the Medicaid State Agency to exchange information with the State Motor Vehicle Accident report files.

2. Impact of Practice

   2.1 **Affected Segment of Caseload:**

   This practice impacts upon the entire case universe.

   2.2 **Savings:**

   The data match has not been in place long enough to report and compare recoveries, and cost avoidance savings.

3. Ongoing, Operational, Annualized Cost

   $51,325 including a monthly charge of $35 to cover Motor Vehicle Division's ongoing costs.

4. Implementation Costs/Times

   $ 4,000

5. State Specific Features

   Information is transferred electronically on a monthly basis. The match is made using name and date of birth because social security numbers are not carried on the State Motor Vehicles Division system. Information is provided for the drivers involved in the accident only. Information being transferred is limited in nature, requiring the State Agency to conduct followup activities in order to determine potential liability situations and to identify third party resources. Matches are checked against the Medicaid Management Information System (MMIS) Expense Avoidance file (trauma claims) to avoid duplicating effort.

5. State Specific Features (continued)

The data exchange is further automated by transferring the information from the mainframe computer to a floppy disk. Information transferred is adequate to establish data base records for several hundred accidents in a matter of seconds. By using selected data elements, the software generates the initial letters to recipients. The data base also serves as a tickler file, and will locate and send followup letters to those recipients who failed to respond to the initial letter. The software is capable of producing any number of reports which is useful in managing followup activities.

SECTION II

STATE SUCCESSFUL PRACTICES UNDER DEVELOPMENT

PART D

Management Practices

Personal Computer Program to Determine Cost Benefit of Purchasing Insurance Premiums *** NEW YORK**

1. Abstract - Current fiscal limitations make it increasingly important that local social services districts maximize the use of third party health coverage to reduce Medicaid expenditures. This increased emphasis is supported in New York law. Social Service Law 367-A provides the basis for Department Regulation 360.17(g) which permits local social service districts to pay private insurance premiums. The Health Insurance Automated Decision Tree (HIADT) is a personal computer program developed by the New York State Department of Social Services Operations Analysis Unit to assist local districts in determining whether or not it is cost effective to pay for a recipient's insurance premium.

When it was implemented in 1989, the program was copied on discs and sent to each local district office. Work is currently being done to place the program on-line so that it can be assessed via main frame terminals. HIADT uses insurance and Medicaid expenditure data to determine the cost effectiveness of a particular policy being reviewed.

The insurance data used are premium costs and services covered by the policy. The Medicaid expenditure data used are sorted by aid category, geographic area, age, sex, and service category.

2. Impact of Practice

   2.1 Affected Segment of Caseload:

   This program can be used for applicants/recipients in the following program areas: Aid to Dependent Children, Home Relief, Supplemental Security Income, and Medical Assistance Only.

   2.2 Savings:

   Unknown

2.3 Other Benefits:

The use of this computer program greatly decreases the time needed to determine if any insurance premium should be paid by Medicaid, and therefore, provide more time for other third party related duties.

3. Ongoing Operational Annualized Costs

Minimal

4. Implementation Costs/Times

$60,000 in expenses related to the extrapolation of data from a wide variety of sources within the New York State MMIS system. Development took six to eight months.

SECTION II - TPL PRACTICE D-2

Computerized Recipient Claims Payments to Expedite Reimbursement

* WASHINGTON

1. Abstract - In recent system design and development, Washington State will use an outline file to isolate and select claims to be included on a Computerized Insurance Invoice (CII). This CII will be computer generated upon request (weekly) and provide insurance companies and attorneys with an accurate compilation of claims payments for which the State is seeking recovery. This method replaces a labor intensive system and will rely on an expanded paid claims history file of up to 36 months.

2. Impact of Practice

   2.1 Affected Segment of Caseload:

   Affects all segments of medical assistance populations with paid claims including tort feasor.

   2.2 Savings:

   To be determined; not yet fully implemented.

3. Ongoing, Operational, Annualized Cost

   Because this part of a broader fixed price/month facilities management contract, exact costs are not available. They are estimated to be $1,599/monthly or $19,188 annually.

4. Implementation Costs/Times

   $ 2,300 Unknown

5. State Specific Features

   This system will provide user flexible accounting to attorneys, and on-line selection with weekly update potential. Claims can appear on accounting each time, or additions can simply be included on earlier reports. Attorney notification requirements, together with this CII process, should greatly enhance recoveries and efficiencies in this area.

SECTION II - TPL PRACTICE D-3

Use of Reference Files in TPL Editing (TPL MATRIX) *** ALABAMA**

1. <u>Abstract</u> - In an effort to make TPL-claims processing editing more responsive to increasing changes in the Medicaid program, Alabama has changed from hard-coded TPL edits within the claims processing modules to editing from a User-Reference File. This practice gives State staff more accurate control of TPL edits as well as timely implementation of edits.

2. <u>Impact of Practices</u>

   2.1 **Affected Segment of Caseload:**

   This practice has potential impact on the entire case universe.

   2.2 **Savings:**

   Implementation of Reference Files was effective for claims processed April 23, 1990, and after. Therefore, savings have not been documented. The State expects the long term impact will be increased savings to Medicaid through more timely filing of claims and the increase in the number of claims filed.

   2.3 **Other Benefits:**

   Control of TPL editing by State TPL staff, timeliness, and ease of updating TPL edit criteria.

3. <u>Ongoing, Operational, Annualized Costs</u>

   Minimal

4. <u>Implementation Costs/Times</u>

   $100,000 (approximately) 6 months

   This includes development of User-Reference Files, as well as, redesign of the TPL retroactive process using Reference Files; modification of recipient history screens; and, design and development of a file-driven TPL cost avoidance editing module.

5. State Specific Features

Alabama modified its TPL Claims Processing Subsystem by converting existing TPL logic to a file driven process. This involved developing a User-Reference File which defines TPL edit criteria in such a way that the edits are placed on an updatable file. Only file maintenance is needed to change an edit rather than programming changes.

The Reference File consists of multiple edit criteria for each coverage type identified to the TPL data base, i.e., hospital inpatient, surgery, dental, office visits, etc. Data on submitting claims is compared against each coverage type in the TPL data base. If the claim meets the criteria for coverage as defined by the Reference File, the claim is cost avoided or paid and chased in accordance with Reference File criteria.

Health Expense Recovery Operations System (HEROS) * OKLAHOMA

1. Abstract - The Oklahoma Department of Health Services uses an "Aging Analysis" System designed to provide the following:

   a. Detailed TPL case record accounting of case activity;
   b. automated letter/memorandum production and case record updates;
   c. "aging/tickler" reports;
   d. statistical information;
   e. management tool to monitor individual caseload activity and production.

   Every potential and established TPL case record is encoded into the "Tickler" file and given a "Reastat" code which has an assigned "Reastat" age. The "Reastat" code describes the current action taken upon the case. The "Reastat" age forces the record to report when the record has aged the pre-determined number of days.

   When the TPL case activity requires a letter or memorandum, the corresponding "Reastat" code is used. When the initial letter has aged the pre-determined number of days, the system will automatically update the record to reflect a followup letter status, and produce the followup letter.

2. Impact of Practices

   2.1 Affected Segment of Caseload:

   Has impact on entire case universe.

   2.2 Savings:

   No savings are directly attributable to this practice. However, potential savings may be attributed to timely followup and expedient retrieval of information.

   2.3 Other Benefits:

   A sense of competition and incentive is created by comparative reporting of performance statistics among TPL staff. Secondly, the manager has a powerful management tool that enables the detection of weak performance and

highlights specific areas that need attention and training. These procedures improve the overall efficiency and effectiveness of the recovery progress.

3. Ongoing, Operational, Annualized Costs

Approximately $5,000 annually

4. Implementation Costs/Times

Unknown

5. State Specific Features

The system provides a storage place for a case accumulating to its cost-effective threshold amount, keeps a record of the case location if referred elsewhere, identifies the reason for case closure, reflects the TPL amount pursued (post amounts), and TPL amount collected (recovered). (The uncollected amount is not maintained within the system, but is calculated by the system and reported).

For additional information, please contact the Oklahoma TPL program supervisor.

SECTION III

MODEL LEGISLATION

SECTION III - MODEL LEGISLATION # 1

Subrogation Rights of Medicaid Agencies

ARKANSAS
INDIANA
MICHIGAN
** MINNESOTA
** MISSOURI
OHIO
WASHINGTON

1. Abstract - These are basic subrogation laws which give State agencies statutory authority to place their demands ahead of (or as part of) any other claim for payment, against any insurer of a recipient of service, any tort feaser, or insurer of a tort feaser, up to the extent of the value of medical services provided to the recipient.

2. Impact of Model Legislation - These pieces of legislation enable States to enforce their status as "payer of last resort" with respect to services provided under Medicaid, by placing themselves ahead of Medicaid recipients and other claimants, with respect to any health insurance contract and any claim filed against a tort feaser. Subrogation laws in different States are all intended to accomplish the same general purpose, but each law has its own characteristics. Following are laws for a number of States with an example of the required language.

ARKANSAS STATUTE

83-161. Action against third person liable for injury, disease or disability of medical assistance recipient.

A. When medical assistance benefits are provided or will be provided to a medical assistance recipient because of injury, disease or disability for which another person is liable, the Department of Human Services shall have a right to recover from such person the cost of benefits so provided. The Department may, to enforce such right, institute and prosecute legal proceedings against the third person who may be liable.

B. No action taken on behalf of the Department pursuant to this section or any judgment rendered in such action shall be a bar to any action upon the claim or cause of action of the recipient, his guardian, personal representative, estate or survivors against the third person who may be liable for the injury, or shall operate to deny to the recipient the recovery for that portion of any damages not covered hereunder.

83-171.1. Action against a third person by a medical assistance recipient or a person entitled to bring action.

A. When an action or claim is brought by a medical assistance recipient or his legal representative against a third party who may be liable for injury, disease, disability or death of a medical assistance recipient, any settlement, judgment, or award obtained is subject to the Department's claim for reimbursement of the benefits provided to the recipient under the medical assistance program.

B. (Repealed.)

83-171.2. Action against a third person by the Department and medical assistance recipient.

If an action is prosecuted both by the recipient and the Department against a third person who is liable for injury, disease, or disability of the recipient, in the event of judgment of award in a suit or claim against such third party, the court shall first order paid from any judgment or award the reasonable litigation expenses incurred in prosecution of such action or claim, together with reasonable attorney's fees based solely on the services rendered for the benefit of the recipient. After payment of such expenses and attorney's fees, the court shall order that the Department receive an amount sufficient to reimburse the Department the full amount of benefits paid on behalf of the recipient under the medical assistance program. The remainder shall be awarded to the medical assistance recipient.

83-171.3 Notice of action or claim - Intervention - Consolidation

A. If either the medical assistance recipient or the Department brings an action or claim against such third person, the recipient or Department shall, within 30 days of filing the action, give to the other written notice of the action or claim by personal service or registered mail. This notice shall contain the names of the third person and the court in which the action is brought. Proof of such notice shall be filed in such action. If an action or claim is brought either by the Department or the recipient, the other may, at any time before a trial on the facts, become a party to the action, or shall consolidate his action or claim with the other if brought independently.

B. If the recipient, his guardian, personal representative, estate or survivors brings an action against the third person who may be liable for injury, disease or disability, notice of institution of legal proceedings and notice of settlement shall be given the

Secretary of the Department of Human Services. All such notices shall be given by the attorney retained to assert the recipient's claim, or by the recipient, his guardian, personal representative, estate or survivors, if no attorney is retained.

83.171.4. No judgment, award, settlements satisfied without notice to Division - Liability for misuse of funds.

No judgment, award of (or) settlement in any action or claim by a medical assistance recipient to recover damages for injuries, disease or disability, in which the Division has interest, shall be satisfied without first giving the Division notice and a reasonable opportunity to establish its interest. If, after being notified in writing of a subrogation claim and possible liability under this section, a recipient, his guardian, attorney, or personal representative disposes, without the written approval of the Division under this section, that person shall be liable to the Division for any amount that, as a result of the disposition of the funds, is not recoverable by the Division.

83-171.5. Liability of third parties to Division.

All parties who were legally liable for any or part of any medical cost of an injury, disease or disability for which the Medicaid program, established by Arkansas Statutes, Section 83-162, has paid, or has assumed liability to pay, shall be liable to the Division of Social Services for the amount of their liability to the extent that the Division of Social Services has paid or agreed to pay.

83.171.6. Assignment to Division of rights of recovery.

The receipt of medical assistance under the Medicaid program shall constitute an automatic assignment to the Division of Social Services of the recipient's right to recovery from personal insurance or other sources or the right of recovery for personal injuries occasioned by the negligence or wrong of another to the extent of the cost of medical care services paid for by the Medicaid program.

83.171.7. Release of information to Division.

All recipients of medical assistance under the Medicaid program shall be deemed to have authorized all third parties including, but not limited to, insurance companies and providers of medical care, to release to the Division of Social Services information needed by the Division to secure or enforce its rights as assignee under Section 4 (83-171.5) of this Act.

83-171.8 Insurance policies - Prohibition against denial or reduction of benefits.

No policy of accident or illness insurance issued or renewed after July 1, 1981, shall contain any provision denying or reducing benefits because services are rendered to an insured or dependent who is eligible for medical assistance under the Arkansas Medicaid program.

83-171.9. Service plan corporation contracts - Prohibition against denial or reduction of benefits.

After July 1, 1981, no service plan corporation shall deliver, issue for delivery, or renew any subscriber's contract which contains any provision denying or reducing benefits because services are rendered to a subscriber or dependent who is eligible for medical assistance under the Arkansas Medicaid program.

83-171.10 Health care providers - Prohibition against denial or reduction of benefits.

After July 1, 1981, no association authorized to do business in this State which provides or pays for any health care benefits shall issue any certificate which contains any provision denying or reducing benefits because services are rendered to a certificate holder or beneficiary who is eligible for medical assistance under the Arkansas Medicaid program.

83-171.11 Exclusion or reduction provisions.

Exclusion or reduction provisions construed as inapplicable to general exclusion or reduction provisions relating to benefits paid by or eligibility under governmental programs, whether State or Federal shall, not be construed to apply to the Medicaid program.

83-171.12 Billing statements.

Billing statements forwarded to recipients of medical assistance by vendors of medical care shall clearly state that reimbursement from the Medicaid program is contemplated.

INDIANA STATUTE

Indiana Code 12-1-7-14.9(g)

"Insurer" means any insurance company, prepaid health care delivery plan, self-funded employee benefit plan, pension fund, retirement system, or similar entity that:

(1) does business in this State; and

(2) is under an obligation to make payments for medical services as a result of an injury, illness, or disease suffered by an individual.

Indiana Code 12-1-7-24.1

(a) Every applicant for or recipient of medical assistance under this chapter is considered to have authorized all insurers to release to the department all information needed by the department to secure or enforce its rights under this chapter.

(b) Every insurer shall furnish records or information pertaining to the coverage of any individual for that individual's medical costs under any individual or group policy or other obligation, or the medical benefits paid or claims made under such a policy or obligation, if the department:

(1) requests the information in writing; and

(2) certifies that the individual is:

(A) an applicant for or recipient of medical assistance; or,

(B) is a person who is legally responsible for such an applicant or recipient.

However, the department may request only the records or information necessary to determine whether any insurance benefits have been or should have been claimed and paid with respect to items of medical care and services that were received by a particular individual and for which medical assistance coverage would otherwise be available.

(c) The administrator and the insurance commissioner shall establish guides for information requests under this section.

Indiana Code 12-1-7-24.2

(a) Whenever:

(1) an insurer has not discharged its obligation to make payments to an individual for medical services;

(2) that individual has (received medical assistance) from the department; and

(3) the insurer has (received notice that medical assistance has been furnished to the individual); the insurer shall make its payments directly to the department. These payments shall not exceed the amount of medical assistance paid by the department.

(b) An insurer that is put on notice of a claim by the department under subsection (a) and proceeds to pay the claim to a person or entity other than the department is not discharged from payment of the department's claim.

(c) Payment to the department by an insurer under this section discharges the insurer's obligation with respect to all further payment on the claim for the amount paid.

(d) The notice requirements of subsection (a) are satisfied if:

(1) the insurer receives from the department, by certified or registered mail, a statement of the claims or medical services rendered by the department, together with a claim for reimbursement; or,

(2) the insurer receives a claim from a beneficiary stating that the beneficiary has applied for or has received medical assistance from the department in connection with the same claim.

An insurer that receives a claim under subdivision (2) shall notify the department of its obligation on the claim and shall pay the obligation to the provider of service, or, if the department has provided medical assistance, pay the department.

Indiana Code 12-1-7-24.6

(a) Whenever:

(1) the department pays medical expenses for or on behalf of a person who has been injured or has suffered an illness or disease as a result of the negligence or act of another person; and

(2) the injured or diseased person asserts a claim again st the other person for damages resulting from the injury, illness or disease; the department has a lien against the other person, to the extent of the amount paid by the department,on any recovery under the claim, whether by judgement, compromise, or settlement.

(b) Whenever:

(1)the department pays for medical expenses or rendered medical services on behalf of a person who has been injured or has suffered an illness or disease; and

(2)that person asserts a claim against any insurer of his injury, illness, or disease; the department has a lien against the insurer, to the extent of the amount paid by the department, on any recovery from the insurer.

(c) A lien under this section is not effective unless the department takes the following actions before the party alleged to be liable has concluded a final settlement with the injured, ill, or diseased person, or his attorney or legal representative, as compensation for that person's injury, illness, or disease.

(1) Filing in the Marion County circuit court a written notice stating:

(A) notice of the eligibility of the injured, ill, or diseased person for medical assistance;
(B) the name and address of the injured, ill, or diseased person; and
(C) the name of the person, firm, or corporation alleged to be liable to the injured, ill, or diseased person.

(2) Sending to the person, firm or corporation alleged to be liable, by registered or certified mail, a copy of the notice required by subdivision (1), with a statement of the date of the filing of that notice.

(d) In addition to the requirements of subsection (c), the department shall send a copy of the notice required by subsection (c)(1) to the following persons or entities, if the appropriate names and address can be determined:

(1) the injured, ill, or diseased person for whom the department has paid medical expenses.
(2) any insurance carrier that may be ultimately liable.
(3) any attorney for the injured or diseased person.

(e) The department may, on behalf of the injured, ill, or diseased person, and to perfect a lien provided by this section, initiate and prosecute any action or proceeding against a person, firm, or corporation who may be liable to the injured, ill, or diseased person. The department may initiate such an action or proceeding only if:

(1) the injured, ill, or diseased person has not initiated legal proceedings against the person, firm, or corporation alleged to be liable; and
(2) the time remaining under the statute of limitations for the action or proceedings is six (6) months or less.

(f) Whenever the department recovers money under a lien established by this section, and that recovery is the result of a claim asserted by an injured, ill, or diseased person, the department shall pay its pro rata share of all costs and reasonably necessary expenses incurred in asserting the claim, including:

(1) disposition costs; (2) witness fees; and (3) other costs and expenses.

(g) The department shall pay attorney fees in the amount of twenty-five percent (25 percent) of the department's recovery under the lien, if the claim was collected without initiating legal proceedings, or thirty-three and one-third percent (33 1/3 percent) of the department's recovery under the lien, if the claim was collected by initiating legal proceedings.

(h) The department may waive its rights to assert a lien under this section. If the department does waive its right to a lien, it is not liable for a pro rata share of costs under subsection (f).

MICHIGAN STATE SUBROGATION STATUTE

400.106 "Medically indigent individual" and "medical institution" defined.

(1) A medically indigent individual is defined as:

(a) An individual receiving aid to dependent children, or an individual eligible for aid to dependent children, or children 18 to 21 eligible for aid to dependent children except for their age, and the adult caretakers living with those children, or a child up to 21 years of age although not receiving aid to dependent children who meets the means test under the Aid to Dependent Children program, or an individual receiving or eligible to receive Supplmental Security Income under title XVI of the Social Security Act, 42 U.S.C. 1381 to 1385, or State supplemental thereunder subject to limitations imposed by the director pursuant to title XIX of the Social Security Act, 42 U.S.C. 1396 to 1396k, or

(b) An individual meeting all of the following conditions:

(i) The individual has made application in the manner prescribed by the State department.

(ii) The individual's need for the type of medical assistance available under this Act for which application has been made and the need professionally established and payment for it is not available through the legal obligation of a contractor, public or private, to pay or provide for care without regard to the income or resources of the patient. The department shall be subrogated to any right of recovery which a patient may have for the cost of hospitalization, pharmaceutical services, physician services, nursing services, and other medical services not to exceed the amount of funds expended by the department for care and treatment of the patient. The patient or other person acting in the patient's behalf shall execute and deliver an assignment of claim or other authorizations as necessary to secure the right of recovery to the department. A payment may be withheld under this act for medical assistance for an injury or disability for which the patient is entitled to medical care ... or under any other policy of insurance providing medical or hospital benefits, or both, for the patient unless the patient's entitlement to that medical care or reimbursement is at issue. If a payment is made, the department, to enforce its subrogation right, may (i) intervene or join in an action or proceeding brought

by the injured, diseased, or disabled person, the person's guardian, personal representative, estate, dependents, or survivors, against the third person who may be liable for the injury, disease, or disability, or against contractors, public or private, who may be liable to pay or provide medical care and services rendered to an injured, diseased, or disabled patient, or (ii) institute and prosecute legal proceeding against a third person who may be liable for the injury, disease, or disability, or against contractors, public or private, who may be liable to pay or provide medical care and services rendered to an injured, diseased, or disabled patient, in State of Federal court, either alone or in conjunction with the injured, diseased, or disabled person, the person's guardian, personal representative, State, dependents, or survivors. The Department, in enforcing its subrogation right, shall not satisfy a judgment against third person's property which is exempt from levy and sale. The injured, diseased, or disabled person may proceed in his or her own name, collecting the costs without the necessity of joining the department or the State as a named party. The injured, diseased, or disabled person shall notify the Department of the action or proceeding. An action taken by the disabled person or the Department in connection with the right of recovery afforded by this section shall not operate to deny the injured, diseased, or disabled person any part of the recovery beyond the costs expended on the person's behalf by the Department. The costs of legal action initiated by the State shall be paid by the State. A payment shall not be made under this act for medical assistance for an injury, disease, or disability for which the patient is entitled to medical care or the cost thereof. . .; except that payment may be made if an appropriate application for medical care or the cost of the medical care has been made under thereto has not been finally determined, and an arrangement satisfactory to the State Department has been made for reimbursement if the claim under Act No. 317 of the Public Acts of 1969, as amended, if finally sustained.

(iii) The individual has an annual income which is below or, because of medical expenses, falls below the protected basic maintenance level. The protected basic maintenance level for aid to dependent children related families shall be 100 percent of the basic aid to dependent children standard of need. The protected basic maintenance level for related individuals under title XVI of the Social Security Act, 42, U.S.C. 1381 to 1385, shall be established by the State Department in an amount not less than the Supplemental Security Income supplementation standard. These levels shall

(iv) The individual, if an aid to dependent children related individual and living alone, has liquid or marketable assets of not more than $1,500.00 in value, or, if a 2-person family, the family has liquid or marketable assets of not more than $2,000.00 in value, the Department shall establish comparable liquid or marketables asset amounts for larger family groups. Excluded in making the determination of the value of liquid or marketable assets are the values of: the homestead, clothing and household effects, $1,000.00 of cash surrender value of life insurance, except if the health of the insured is such as to make continuance of the insurance desirable, the entire cash surrender value of life insurance is to be excluded from consideration, up to the maximums provided or allowed by Federal regulations and in accordance with the rules of the State Department, the fair market value of tangible personal property used in earning income, and a space or plot purchased for the purposes of burial for the person. For individuals related to the title XVI program of the Social Security Act, 42 U.S.C. 1381 to 1385, the appropriate resource levels and property exemptions specified therein shall be used.

(v) The individual is not an inmate of a public institution except as a patient in a medical institution.

(vi) The individual meets the eligibility standards for Supplemental Security Income under title XVI of the Social Security Act, 42 U.S.C. 1381 to 1385, or State Supplementation under the Act, subject to limitations imposed by the director pursuant to title XIX of the Social Security Act, 42 U.S.C. 1396 to 1396k, or for aid to dependent children, except for income or income and resources, or a child 18 to 21 and his adult caretaker who would be eligible for aid to dependent children except for age, income, or income and resources, or he is a child under 21 from a family whose income is below the basic maintenance level.

(2) As used in the Act, "medical institution" means a State licensed or approved hospital, nursing home, medical care facility, psychiatric hospital, or other facility or identifiable unit thereof certified as meeting established standards for a nursing home or hospital in accordance with the laws and rules of this State.

256B.37 PRIVATE INSURANCE POLICIES, CAUSES OF ACTION.

Subdivision 1. Subrogation. Upon furnishing medical assistance to any person having private accident or health care coverage, or having a cause of action arising out of an occurrence that necessitated the payment of medical assistance, the state agency shall be subrogated, to the extent of the cost of medical care furnished, to any rights the person may have under the terms of the coverage or under the cause of action.

The right of subrogation created in this section includes all portions of the cause of action, notwithstanding any settlement allocation or apportionment that purports to dispose of portions of the cause of action not subject to subrogation.

Subd. 2. Civil action for recovery. To recover under this section, the attorney general, or the appropriate county attorney, acting upon direction from the attorney general, may institute or join a civil action to enforce the subrogation rights established under this section.

Subd. 3. Notice. The state agency must be given notice of monetary claims against a person, firm, or corporation that may be liable in damages, or otherwise obligated to pay part or all of the cost of medical care when the state agency has paid or become liable for the cost of care. Notice must be given as follows:

(a) Applicants for medical assistance shall notify the state or local agency of any possible claims when they submit the application. Recipients of medical assistance shall notify the state or local agency of any possible claims when those claims arise.

(b) A person providing medical care services to a recipient of medical assistance shall notify the state agency when the person has reason to believe that a third party may be liable for payment of the cost of medical care.

(c) A person who is party to a claim upon which the state agency may be entitled to subrogation under this section shall notify the state agency of its potential subrogation claim before filing a claim, commencing an action, or negotiating a settlement.

Notice given to the local agency is not sufficient to meet the requirements of paragraphs (b) and (c).

Subd. 4. Recovery. Upon any judgment, award, or settlement of a cause of action, or any part of it, upon which the state agency has a subrogation right, including compensation for liquidated, unliquidated, or other damages, reasonable costs of collection, including attorney fees, must be deducted first. The full amount of medical assistance paid to or on behalf of the person as a result of the injury must be deducted next and paid to the state agency.

AN EQUAL OPPORTUNITY EMPLOYER

STATE OF MISSOURI'S MEDICAID STATUTE RELATING TO

SUBROGATION/LIEN/ASSIGNMENT OF BENEFITS

208.215. Subrogation—liens—rights of department, when, procedure, exception—report of injuries required, form—recovery of medical assistance paid, when.—1. When any person, corporation, institution, **public agency** or private agency is liable, either pursuant to contract or otherwise, to a recipient of public assistance on account of personal injury to or disability or disease of the recipient or of a minor on whose behalf public assistance is granted, the department of social services is subrogated to the right of the recipient, minor or estate on whose behalf public assistance is granted to recover from such person from any award or settlement an amount not to exceed the payments made or allowable from medical assistance provided under sections 208.151 to 208.158 and section 208.162 on behalf of the recipient, minor or estate for medical care and treatment on account of the injury, disease, or disability.

2. The department of social services may maintain an appropriate action to recover funds due under this section in the name of the state of Missouri against the person, corporation, institution, public agency or private agency liable to the recipient, minor or estate.

3. Any recipient, minor, guardian, conservator, personal representative, estate, or person entitled under section 537.080, RSMo, to bring an action for wrongful death who pursues legal rights against a person, corporation, institution, public agency or private agency liable to that recipient or minor for injuries, disease or disability as outlined in subsection 1 of this section shall promptly notify the department as to the pursuance of such legal rights.

4. As a condition of eligibility for medical assistance under sections 208.151 to 208.159 and section 208.162, all applicants and recipients, including a person authorized by the probate code, shall cooperate with the department of social services in identifying and providing information to assist the state in pursuing any third party who may be liable to pay for care and services available under the state's plan for medical assistance as provided in sections 208.152 and 208.162, unless such applicant or recipient has good cause for refusing to cooperate as determined by the department of social services in accordance with federally prescribed standards.

5. Every person, corporation or partnership who acts for or on behalf of a person who is or was eligible for medical assistance under sections 208.151 to 208.159 and section 208.162 for purposes of pursuing the applicant's or recipient's claim which accrued as a result of an incident or occurrence resulting in the payment of medical assistance benefits, shall notify the department upon agreeing to assist such person and further shall notify the department of any institution of a proceeding, settlement or the results of the pursuit of the claim.

6. Every recipient, minor, guardian, conservator, personal representative, estate, or person entitled under section 537.080, RSMo, to bring an action for wrongful death, or his attorney or legal representative shall promptly notify the department of any recovery from a third party and shall immediately reimburse the department in full from the proceeds of any settlement, judgment, or other recovery in any action or claim initiated against any such third party.

7. The department director shall have a right to recover the full amount of payments made to a provider under this chapter because of an injury, disease, or disability for which a third party is or may be liable in contract, tort or otherwise under law or equity. The department director is prohibited from reducing the recovery of payments by any fees, costs or other expenditures incurred by any person, corporation or partnership.

8. The department of social services shall have a lien upon any moneys to be paid by any insurance company or similar business enterprise in settlement or satisfaction of a judgment on any liability claim for injuries which resulted in medical expenses for which the department made payment. This lien shall also be applicable to any moneys which may come into the possession of any attorney who is handling the claim for injuries which resulted in medical expenses for which the department made payment. No such lien shall be effective unless a written notice containing the name and address of the recipient of medical assistance is sent by the department by registered mail, with return receipt requested, to the person, corporation, institution, public agency or private agency alleged to be liable to the recipient prior to the payment of any moneys to such recipient or his attorney or legal representative.

9. From funds recovered pursuant to this section the federal government shall be paid a portion thereof equal to the proportionate part originally provided by the federal government to pay for medical assistance to the recipient or minor involved.

10. The right of subrogation provided by this section is subordinate to the lien provided by section 484.130, RSMo, or section 484.140, RSMo, relating to an attorney's lien and shall be applicable to cases in which workers' disability compensation insurers are the liable third party. The provisions against assignment of this compensation contained in section 287.260, RSMo, shall not be applicable in cases where the state has paid medical assistance benefits.

11. Application for and acceptance of medical assistance under this chapter shall constitute an assignment to the department of social services of any rights to support for the purpose of medical care as determined by a court or administrative order and of any other rights to payment for medical care.

12. All recipients of benefits as defined in this chapter shall cooperate with the state by reporting to the division of family services, within thirty days, any occurrences where an injury to their person or to a member of a household who receives medical assistance is sustained, on such form or forms as provided by the division of family services.

13. If a person fails to comply with the provision of any judicial or administrative decree for temporary order requiring that person to maintain medical insurance on or be responsible for medical expenses for a dependent child, spouse, or ex-spouse, in addition to other remedies available, that person shall be liable to the state for the entire cost of the medical care provided pursuant to eligibility under any public assistance program on behalf of that dependent child, spouse, or ex-spouse during the period for which the required medical care was provided. Where a duty of support exists and no judicial or adminstrative decree or temporary order for support has been entered, the person owing the duty of support shall be liable to the state for the entire cost of the medical care provided on behalf of the dependent child or spouse to whom the duty of support is owed.

14. The department director or his designee may compromise, settle or waive any such claim in whole or in part in the interest of the medical assistance program.

(L. 1981 H.B. 901 § 1, A.L. 1982 H.B. 1036, A.L. 1987 H.B. 518)

STATE OF MISSOURI'S WORKERS COMPENSATION STATUTE RELATING TO MEDICAID'S SUBROGATION/LIEN/ASSIGNMENT OF BENEFITS

287.266. Payments made to public assistance recipients to be a debt due state, recovery by state—attorney's fees—assignment of rights—apportionment by judge, when.—1. As used in this section, the following terms mean:

(1) "Provider", any individual, corporation, public or private entity that has entered into an agreement with the state to provide any service set out in section 208.152, RSMo, and subsequent amendments;

(2) "Person eligible for public assistance", any individual who is or was eligible for medical assistance under the laws of this state.

2. Payments made to or on behalf of a person eligible for public assistance as the result of any compensable injury, occupational disease or disability as defined by this chapter shall be a debt due the state, and recovery of same shall be a recognized action pursuant to this chapter.

3. The state shall have a lien upon any funds owed by any employer that are or might be due under any insurance agreement or self-insurance authority in effect at the time the medical expense or any portion thereof was paid by the department of social services or its designated division.

4. The state shall have a right of subrogation to any funds owed to or received by the employee or any person, corporation, public agency or private agency acting on his behalf notwithstanding any other provisions of this chapter.

5. The department of social services or its designated division may maintain an appropriate action to recover funds due under this section pursuant to the workers' compensation law or the second injury fund, which includes the exercise of all appeal rights afforded by the laws of this state.

6. The department shall have a right to recover the full amount of its payments when payments are made to a provider under this chapter if the payments were made on behalf of a person eligible for public assistance for an injury, occupational disease, or disability which is compensable under this chapter.

7. This debt due the state shall be subordinate only to the fee rights of the injured employee's attorney pursuant to this chapter, and the state shall not be required to pay any portion of the fees or costs incurred by the employee or the employer.

8. Application for and acceptance of public assistance made to or on behalf of the injured employee shall constitute an assignment of rights to the department of social services for reimbursement of funds expended by the department of social services in the treatment of

9. The attorney shall notify the department of social services upon representation of each client who was eligible for public assistance as provided by sections 208.151 to 208.159, RSMo, and section 208.162, RSMo, prior to, during or subsequent to the date of injury, that the attorney was retained to pursue the client's legal rights related to the compensable injury.

10. The administrative law judge, pursuant to authority granted under section 287.610, shall apportion the debt due the state between the injured worker and the injured worker's employer or their designated representatives when an agreement cannot be reached regarding the respective liability for money expended by the department of social services on behalf of the injured employee, but in no case shall the debt due the state be reduced.

(L. 1987 H.B. 518)

SECTION III - MODEL LEGISLATION #1 (continued)

OHIO STATUTE

5101.58 Right of subrogation

The acceptance of aid ... gives a right of subrogation to the Department of Public Welfare and the Department of Welfare of any county against the liability of a third party for the cost of medical services and care arising out of injury, disease, or disability of the recipient. When an action or claim is brought against a third party by a recipient of aid ..., the entire amount of any settlement or compromise of the action or claim, or any court award or judgment is subject to the subrogation right of the Department of Public Welfare of the Department of Welfare of any county. The Departments' subrogation claim shall not exceed the amount of medical expenses paid by the Departments on behalf of the recipient. Any settlement, compromise, judgment, or award that excludes the cost of medical services or care shall not preclude the Departments from enforcing their rights under this section.

Prior to initiating any recovery action, the recipient or his representative shall disclose the identification of any third party against whom the recipient has or may have a right of recovery. Disclosure shall be made to both the Department of Public Welfare and the appropriate County Welfare Department when medical expenses have been paid. No settlement, compromise, judgment, or award or any recovery in any action or claim by a recipient where the Departments have a right of subrogation shall be made final without first giving the appropriate Departments notice and a reasonable opportunity to perfect their rights of subrogation. If the Departments are not given appropriate notice, the recipient is liable to reimburse the Departments for the recovery received to the extent of medical payments made by the Departments. The Departments shall be permitted to enforce their subrogation rights against the third party even though they accepted prior payments in discharge of their rights under this section if, at the time the Departments received such payments, they were not aware that additional medical expenses had been incurred but had not yet been paid by the Departments. The third party becomes liable to the Department of Public Welfare or County Department of Welfare as soon as the third party is notified in writing of the valid claim for subrogation under this section.

Subrogation does not apply to that portion of any judgment, award, settlement, of compromise of a claim, to the extent of attorney's fees, costs, or other expenses incurred by a recipient in securing the judgment, award, settlement, or compromise, or to the extent

of medical, surgical, and hospital expenses paid by such recipient from his own resources. Attorney fees and costs of other expenses in securing any recovery shall not be assessed against any subrogated claims of the Departments.

To enforce their subrogation rights, the Departments may do any of the following:

(A) Intervene or join in any action or proceeding brought by the recipient or on his behalf against any third party who may be liable for the cost of medical services and care arising out of the recipient's injury, disease, or disability;

(B) Institute and pursue legal proceedings against any third party who may be liable for the cost of medical services and care arising out of the recipient's injury, disease, or disability.

SECTION III - MODEL LEGISLATION # 1

WASHINGTON STATUTE

The revised statute (RCW 43.20B) gives Washington the statutory authority to place demands ahead of claim for payment, against any insurer of a recipient of service, any tort feasor, or insurer of a tort feasor, up to the extent of the value of medical services provided to the recipient. It recognizes prorated court costs and proportionate attorney fees.

This legislation (modified to include attorney notification in 1990) enables Washington to enforce their status as "payor of last resort" with respect to services provided under Medicaid, by inserting themselves ahead of Medicaid recipients and other claimants, into any insurance contract and any claim filed against a tort feasor.

The statutory language in Section 7 is as follows:

(1) To secure reimbursement of any assistance paid under Chapter 74.09 RCW[1] or reimbursement for any residential care provided by the Department at a hospital for the mentally ill or habilitative care center for the developmental disabled, as a result of injuries to or illness of a recipient caused by the negligence or wrong of another, the Department shall be subrogated to the recipient's rights against a tort feasor or the tort feasor's insurer, or both.

(2) The Department shall have a lien upon any recovery by or on behalf of the recipient from such tort feasor or the tort feasor's insurer, or both to the extent of the value of the assistance paid or residential care provided by the Department, provided that such lien shall not be effective against recoveries subject to wrongful death when there are surviving dependents of the deceased. The lien shall become effective upon filing with the county auditor in the county where the assistance was authorized or where any action is brought against the tort feasor or insurer. The lien may also be filed in any other county or served upon the recipient in the same manner as a civil summons if, in the Department's discretion, such alternate filing or service is necessary to secure the Department's interest. The additional lien shall be effective upon filing or service.

[1]Chapter 74.09 RCW relates to Medical Assistance payments and RCW 43.20B relates to recovery.

(3) The lien of the Department shall be upon any claim, right of action, settlement proceeds, money, or benefits arising from an insurance program to which the recipient might be entitled; (a) against the tort feasor or insurer of the tort feasor, or both, and (b) under any contract of insurance purchased by the recipient or by any other person providing coverage for the illness or injuries for which the assistance or residential care is paid or provided by the Department.

(4) If recovery is made by the Department under this section and the subrogation is fully or partially satisfied through an action brought by or on behalf of the recipient, the amount paid to the Department shall bear its proportionate share of attorneys' fees and costs. The determination of the proportionate share to be born by the Department shall be based upon:

(a) The fees and costs approved by the court in which the action was initiated; or

(b) The written agreement between the attorney and client which establishes fees and costs when fees and costs are not addressed by the court.

(c) When fees and costs have been approved by a court, after notice to the Department, the Department shall have the right to be heard on the matter of attorneys' fees and costs, or its proportionate share.

(d) When fees and costs have not been addressed by the court, the Department shall receive at the time of settlement a copy of the written agreement between the attorney and client which established fees and costs and may request and examine documentation of fees and costs associated with the case. The Department may bring an action in superior court to void a settlement if it believes the attorney's calculation of its proportionate share of fees and costs is inconsistent with the written agreement between the attorney and client which establishes fees and costs or if the fees and costs associated with the case are exorbitant in relation to cases of a similar nature.

The new Section 8 is added to Chapter 43.20B RCW to read as follows:

An attorney representing a person who, as a result of injuries or illness sustained through the negligence or wrong of another, has received, is receiving, or has applied to receive assistance under Chapter 74.09 RCW, or residential care provided by the Department at a hospital for the mentally ill or habilitative care center for the developmentally disabled, shall:

(1) Notify the Department at the time of filing any claim against a third party, commending an action at law, negotiating a settlement, or accepting a settlement offer from the tort feasor or the tort feasor's insurer, or both; and

(2) Give the Department thirty days' notice before any judgment, award, or settlement may be satisfied in any action or any claim by the applicant or recipient to recover damages for such injuries or illness.

PROVISIONS OF WASHINGTON LAW

Recipient or attorney must notify State agency of any third party claim within a reasonable time.

Agency has right to perfect a lien.

Agency will pay a portion of legal fees related to third party information.

Once notified of specific liability, insurers must reimburse the State agency regardless of payments made to others, even if insured is not a recipient but is legally responsible for one.

SECTION III - MODEL LEGISLATION #2

Co-Endorsement of Insurance Checks by Providers WASHINGTON

1. Abstract - This law requires that all checks from health care service contractors regulated under State law be made payable to and endorsed by both the insured and the provider of service.

2. Impact of Model Legislation - The purpose of this legislation is to prevent individuals from receiving monies due the State agency in reimbursement for paid Medicaid services and not reporting those payments to the agency. In particular, the law is aimed at absent parents of Medicaid eligible children, whose insurance policies make payment directly to them.

   This legislation offers recourse to providers that should have received payments that were made directly to the insured. Banks in Washington that honor such checks without both endorsements being present are subject to collection proceeding by any other party to whom payment should have been made.

STATE OF WASHINGTON

An ACT Relating to health care services; BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

Sec. 1, Section 1, Chapter 168, Laws of 1982 and RCW 48.44.026 are each amended to read as follows.

> Checks in payment for claims pursuant to any health care service contract for health care services provided by persons licensed or regulated under chapter 18.22, 18.25, 18.29, 18.32 or 18.53 or 18.71 RCW, where the provider is not a participant under a contract with the health care service contractor, shall be made out to both the provider and the insured, jointly, to require endorsement by each. PROVIDED, that payment shall be made in the single name of the insured if the insured as part of his or her claim furnishes evidence of prepayment to the health care service provider: AND PROVIDED FURTHER, that nothing in this section shall preclude a health care service contractor from voluntarily issuing payment in single name of the provider.

SECTION III - MODEL LEGISLATION #3

Third Party Insurers Must Cooperate with State Medicaid Agency's Efforts to Identify Insurance Coverage Available to Medicaid Recipients

** MISSOURI
NEW YORK
OHIO

1. Abstract - Some States require all third parties to cooperate with any attempts by the State agency to identify liability that they may have for services received by Medicaid recipients and paid for by the State agency. Legislation of this type should include provisions that protect the third party from privacy problems by placing the liability stemming from any such actions on the State agency.

2. Impact of Model Legislation -

MISSOURI

This law provides the Medicaid agency contractual capability with any entity defined as an insurance company, health service corporation or health maintenance organization, and any self-insuring organization or business to obtain HI information on a Medicaid recipient.

The purpose of this legislation is to require insurance companies and other defined entities to cooperate in the data match request by the Medicaid agency. Specific provisions include the mode of the data match, payable costs to the entity, penalty for noncompliance, confidentiality requirements, and consent for information.

MISSOURI STATUTE

208.217. Department may obtain medical insurance information-failure to provide information, attorney general to bring action penalty-confidential information, penalty for disclosure-definitions.-1. As used in this section, the following terms mean:

(1) "Entity":
   (a) Any insurance company as defined in chapter 375, RSMo. or any public organization or agency transacting or doing the business of insurance; or
   (b) Any health service corporation or health maintenance organization as defined in chapter 354, RSMo; or any other provider of health services as defined in chapter 354 RSMo; or
   (c) Any self-insured organization or business providing health services as defined in chapter 354, RSMo

(2) "Department", the Missouri Department of Social Services or any division thereof.

(3) "Insurance", any agreement, contract, policy plan or writing entered into voluntarily or by court or administrative order providing for the payment of medical services or for the provision of medical care to or on behalf of an individual;

(4) "Individual", any applicant or present or former recipient of public assistance benefits under sections 208.151 to 208.159 and section 208.162;

(5) "Request", any inquiry by the Division of Medical Services for the purpose of determining the existence of insurance where the department may have expended medical assistance benefits;

(6) "Data match", a method of comparing the department's information with that of another entity and identifying those records which appear in both files. This process is accomplished by a computerized comparison by which both the Department and the entity utilize a computer readable electronic media format.

2. The Department may enter into a contract with any entity, and the entity shall, upon request of the Department of Social Services, inform the Department of any records or information pertaining to the insurance of any individual.

3. The information which is required to be provided by the entity regarding an individual is limited to those insurance benefits that could have been claimed and paid by an insurance policy agreement or plan with respect to medical services or items which are otherwise covered under the Missouri Medicaid program.

4. A request for a data match made by the Department pursuant to this section shall included sufficient information to identify each person named in the request in a form that is compatible with the recordkeeping methods of the entity. Requests for information shall pertain to any individual or the person legally responsible for such individual.

5. The Department shall reimburse the entity which is requested to supply information as provided by this section for actual direct costs, based upon industry standards, incurred in furnishing the requested information and as set out in the contract. The department shall specify the time and manner in which information is to be delivered by the entity to the department. No reimbursement will be provided for information requested by the department other than by means of a data match.

6. Any entity which has received a request from the Department pursuant to this section shall provide the requested information in writing within sixth day of receipt of the request. Willful failure of an entity to provide the requested information within such period shall result in liability to the State for civil penalties of up to ten dollars for each day thereafter. The attorney general shall, upon request of the department, bring an action in a circuit court of competent jurisdiction to recover the civil penalty. The court shall determine the amount of the civil penalty to be assessed.

7. The director of the Department shall establish guidelines to assure that the information furnished to any entity or obtained from any entity does not violate the laws pertaining to the confidentiality and privacy of an applicant or recipient of Medicaid. Any person disclosing confidential information for purposes other than set forth in this section shall be guilty of a class A misdemeanor.

8. The application for or the receipt of benefits under sections 208.151 to 208.159 and section 208.162 shall be deemed consent by the individual to allow the department to request information from any entity regarding insurance coverage of said person.

SECTION III - MODEL LEGISLATION #3

NEW YORK

New York's legislation, specifying privacy safeguards, allows the State agency to initiate data matches with all of the licensed insurance plans in the State. It also facilitates resource identification activities with several other insurance companies, because State and county staff have access to payment and eligibility records for both clients and responsible relatives.

A copy of the legislation is available upon request from the State.

OHIO

Ohio's legislation authorizes the State agency to require third parties to participate in automated data matches, when they are equipped to do so. The immediate impact of this legislation was to overcome resistance from the State's retirement system to cooperating with the Medicaid agency in a data match to determine whether there were Medicaid recipients eligible for benefits from the retirement system's health insurance plan.

The State agency has used the law in conjunction with a TPL Supplemental Recovery Program (contingency fee contractor). Successful data exchanges have occurred with several private carriers. The legislation holds the private firms harmless in privacy considerations; however, private carriers have concerns of potential jeopardy in Federal privacy legislation taking precedence over the State law. This legislation may have useful applications in other States.

A copy of legislation is available upon request from State.

SECTION III - MODEL LEGISLATION #4

Adjudicated Parents Must Execute and Deliver Any Instruments Necessary to Assure the Timely Payment of the Dependent's (s') Health Insurance Claims — **NEW YORK**

1. Abstract - This legislation requires the adjudicated parent to execute and deliver any forms, notices, documents or other instruments necessary to assure the timely payment of any health insurance claims for his/her dependent(s).

2. Impact of the Model Legislation - This legislation goes beyond the normal requirement that court ordered health insurance coverage be provided by making provisions for directing the dependent's(s') health insurance payments. The adjudicated parent is required to supply instruments not only to prove to a provider that coverage exists, but also to allow the provider to bill the available third party (claims forms). Furthermore, in cooperation with its IV-D unit, the third party unit is defining one of these instruments necessary to be an assignment of all health insurance payments for the dependent(s) to the provider of service. This prevents the adjudicated parent from receiving the money thereby reducing IV-D's violation workload.

   A copy of the legislation is available upon request from the State.

SECTION III - MODEL LEGISLATION #5

Model Support Enforcement Through Employer Withholding Requirements — MINNESOTA

1. Abstract - This law requires the obligor to name the minor child as beneficiary on any health and dental insurance plan that is available to the obligor on a group basis or through an employee or union. If the court finds that dependent or dental insurance is not available to the obligor through an employer or union, or that the group insurer is not accessible to the obligee, the court may require the obligor to obtain dependent health or dental coverage, or to be liable for reasonable and necessary medical or dental expenses of the child.

   The Office of Child Support Enforcement regulations published in the Federal Register on October 16, 1985, require the State IV-D agency to petition the Court or Administrative authority to include health insurance coverage in the support order if the absent parent has access to employment related or other group insurance. Some States require legislation to implement the Federal regulations. This model legislation is being provided to assist States in complying with the requirement.

   A copy of the legislation is available upon request from the State.

SECTION III - MODEL LEGISLATION #6

Required Attorney Notification to the Medicaid State Agency

* KENTUCKY
* MAINE

1. **Abstract** - This law requires any attorney representing a Medicaid recipient who makes a claim to recover the medical cost of a injury for which the recipient received medical benefits under the Medicaid program to advise the Medicaid agency of the existence of the claim. The attorney bringing an action on behalf of a recipient must notify the Medicaid agency of that action at least 10 days prior to the filing of the pleadings. A further requirement is that no disbursement of a settlement may be made without proper notification to the Medicaid agency.

2. **Impact of Model Legislation** - The legislation provides the State with the notification of attorney involvement and information regarding the contents of pleadings the attorney intends to file. The State may request the attorney to represent its interest. The requirement involving notification by the attorney of settlement discussions permits State input regarding negotiated settlements on a timely basis.

KENTUCKY

Kentucky legislation requires that at the commencement of an action seeking to recover damages, it shall be the duty of the plaintiff or his attorney to notify, by certified mail, those parties believed by him to hold subrogation rights to any award received by the plaintiff as a result of the action. The notification shall state that a failure to assert subrogation rights by intervention, pursuant to Kentucky Civil Rule 24, will result in a loss of those rights with respect to any final award received by the plaintiff as a result of the action. This applies to all actions for damages, whether in contract or in tact, commenced after July 15, 1988. The legislation also requires that a certified list of all parties notified be filed with the clerk of the court.

A copy of the legislation is available upon request from the State.

MAINE

Maine legislation, which makes this requirement law in the State, follows on the next page.

APPROVED
MAR 23 '88
BY GOVERNOR

CHAPTER
621
PUBLIC LAW

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND EIGHTY-EIGHT

S.P. 759 - L.D. 2022

AN ACT to Enforce 3rd-Party Liability Reimbursement for Medicaid Recipients as Required by Title XIX of the Social Security Act.

Be it enacted by the People of the State of Maine as follows:

22 MRSA §14, sub-§§2-D, 2-E and 2-F are enacted to read:

2-D. Notification of claim. A Medicaid recipient, or any attorney representing a Medicaid recipient, who makes a claim to recover the medical cost of injury, disease, disability or similar occurrence for which the party received medical benefits under the Medicaid program, pursuant to the United States Social Security Act, Title XIX, shall advise the department in writing with information as required by the department of the existence of the claim.

2-E. Notification of pleading. In any action to recover the medical cost of injury, disease, disability or similar occurrence for which the party received medical benefits under the Medicaid program, the party bringing the action shall notify the department of that action at least 10 days prior to filing the pleadings. Department records indicating medical benefits paid by the department on behalf of the recipient shall be prima facie evidence of the medical expenses incurred by the recipient for the related medical services.

2-F. Disbursement. No disbursement of any award, judgment or settlement may be made to a recipient without the recipient or the recipient's attorney first providing at least 10 days' written notice to the department of the award, judgment or settlement or obtaining from the department a release of any obligation owed to it for medical benefits provided to the recipient.

SECTION III - MODEL LEGISLATION # 7

Establish Liability for Medical Expenses for Children - House Bill 352 1990 *** UTAH**

1. Abstract - This law provides for the determination of a parent's liability for uninsured medical expenses by a court or administrative proceeding.

2. Impact of Model Legislation - The primary purpose of this legislation is to allow the State to establish administratively a "sum certain judgment" for past medical and dental expenses when a parent has been made responsible for these cost under a previous judicial or administrative order.

   If the parent has been ordered to maintain insurance for his dependent children and fails to do so, the State may initiate a judicial or administrative proceeding to obtain a judgment for past expenses. In some cases the court also orders the parents to be responsible for uninsured medical expenses at prorated amounts. The State will initiate a judicial or administrative proceeding to obtain a judgment for the specific amount of past medical expenses.

   A copy of the legislation is available upon request from the State.

SECTION III - MODEL LEGISLATION #8

Medical Benefits Recovery Act (Priority Lien) * UTAH
Senate Bill 72 1989

1. Abstract - This law places a statutory lien in favor of the State on all proceeds payable by a third party in behalf of a recipient. The lien is a priority lien over all other claims to the proceeds except certain attorney's fees and legal costs.

2. Impact of the Model Legislation - Prior to this statute, it was not uncommon for private legal counsel representing an injured recipient to negotiate a settlement with a liable party's insurance carrier up to the amount of the policy limits for General Damages. When the State attempted to file a claim at a latter date for specific damages the carrier obviously denied the claim. This statute allows the State to obtain payment to reimburse Medicaid for medical expenses before the issue of general damages is dealt with. It has also strengthened our negotiating position with third parties and the private bar representing injured recipients.

   Utah legislation provides that, when the Medicaid State agency provides or becomes obligated to provide medical assistance to a recipient because of an injury, disease, or disability for which a third party is liable, the agency may recover the medical assistance directly from a third party. The State agency's claim to recover medical assistance provided as a result of injury, disease, or disability shall be a lien against any proceeds payable to the recipient by the third party. The lien has priority over all other claims to the proceeds except attorney fees.

SECTION III - MODEL LEGISLATION # 9

Direct Issuance of Insurance Payments and Denials to Medicaid Providers *** MINNESOTA**

1. <u>Abstract</u> - This law requires health insurers regulated under State law to issue payments and denials directly to the medical provider for Medicaid recipients.

2. <u>Impact of Model Legislation</u> - The purpose of this legislation is to ensure that providers of service receive insurance payments and denial information for Medicaid recipients for whom they are required to bill primary payers under cost avoidance.

   The Minnesota legislation requires that no policy of accident and sickness insurance as regulated under the law shall contain any provision denying or reducing benefits because services are rendered to a person who is eligible for, or receiving medical benefits pursuant to, the provisions of the law. The provider must indicate any benefit coverage on any claim form submitted by the provider to the insurer for those services. In addition, the Minnesota provision requires insurance carriers to issue payment or notice of denial directly to the Medicaid recipient's provider of services or to the Department of Human Services rather than to the policy holder. This provision became effective for insurance claims filed after June 30, 1989.

SECTION IV

STATE TPL TRAINING

Procedures and Techniques

STATE SPECIFIC FEATURES

ARKANSAS

Training Coordinator

Wayne E. Olive, Manager
TPL Unit, Medical Assistance Section
P. O. Box 1437
Little Rock, Arkansas 72203
(501) 271-2388

Arkansas submitted a training package on its MMIS TPL Subsystem. This training guide is used for all new hires as well as a desk reference by all other staff involved in TPL. The trainee has hands-on training on the TPL Subsystem which offers a cost-effective approach to post payment recovery activities.

The trainee is also guided through an example of the TPL resource identification process and documentation requirements. The trainee is requested to provide feedback on the training and make suggestions for changes.

** CALIFORNIA

Training Coordinator

Barbara Carr
Other Coverage Section
Department of Health Services
6620 Folsom Boulevard
Sacramento, California 95819
(916) 739-3204

The Department of Health Services contracted with the California State University at Sacramento (CSUS) Hornet Foundation to develop a TPL training program. This training is provided to caseworkers in the County Welfare Departments, County District Attorneys, County Veterans Services Officers and the Social Security Administration (SSA) district offices.

The training addresses three learning principles: sight, hearing, and hands-on application. It comprises a nine minute video ("Seconds Save Millions") giving an overview of TPL, a thirty (30) minute lecture with overhead transparencies and a session addressing hands-on application of the correct way to complete forms.

As a result of SSA's presentation of California's TPL training, there has been an increase in TPL inquiries and reporting. The Statewide weighted average of SSA TPL referrals increased by six (6) percent within two months from the month SSA TPL training was given. The initial training was conducted in November 1989. In December, the number of new SSI/SSP eligibles reported with TPL was 170 individuals. In January, the number reported increased to 1,500 individuals with TPL.

County training took place somewhat later and results are still being compiled.

HAWAII

Training Coordinator

Walter Murakami
TPL Training Specialist
Hawaii Department of Human Services
P. O. Box 339
Honolulu, Hawaii 96809
(808) 548-6503

TPL training in Hawaii is conducted yearly and includes a pre-test and a post-test. If an eligibility worker (EW) makes a mistake in the post-test, a followup is made with the EW's supervisor to review the error and correct the mistake(s). These tests also motivate EWs to participate actively in training sessions and conscientiously learn TPL concepts and procedures. Information regarding TPL activity; i.e., cost-savings through cost-avoidance and recoveries, are disseminated periodically to provide further incentive for EWs to learn to apply TPL.

As a part of the training package, the trainee is walked though an illustration of the TPL resource identification process and documentation requirements. The trainee is also afforded an opportunity to evaluate the third party resources training.

** INDIANA

Training Coordinator

Ben Bobo
SDRW TPL Staff
100 N. Senate Avenue
Indianapolis, Indiana 46204
(317) 841-4414

Indiana's training/resource guide highlights statutes governing TPL. The guide is for use by county workers and explains various provisions of the program; e.g., what is a casualty recovery? The guide also includes copies of forms in use, coding definitions, and information included in the State's provider manuals.

KENTUCKY

Danette Warford, Acting Supervisor
TPL Financial Services
P. O. Box 2009
Frankfort, Kentucky 40602
(502) 227-9073, Ext. 315

TPL training is given to new employees on a one to one basis. The new TPL employee training consists of complete familiarization with the TPL Desk Level Manual, computer system training, as well as individual training with a senior TPL caseworker for three to four weeks.

The TPL Desk Level Manual is organized by function, from file updating, to maintaining the recipient TPL database, through the steps required for recovery of benefit dollars. For easy reference, each section includes a sample of each item discussed, followed by the item's reference section for further detailed information. All TPL-related reports, TPL-related on-line screens, and tables of TPL codes and definitions are also included.

** OREGON

Training Coordinator

Steven Cloud
Adult and Family Services Division
Recovery Services Section
Public Service Building, Room 400
Salem, Oregon 97310
(503) 378-3729

TPL training is given to new welfare assistance workers (eligibility technicians) and medical workers during the orientation process. TPL subject matter is organized into a resources training packet which was updated in June 1989. In addition, a Third Party Resources Guidebook is available to all staff with information specifically regarding TPL resources available to Medicaid recipients. These include liability insurances, Veteran's benefits, CHAMPUS benefits, prepaid health plans, and workers compensation.

The Guide serves as a quick and handy reference which explains what the worker is to do with the information obtained. It also lists references as to whom the assistance worker should contact for answers to any questions which may arise. Retraining of workers is conducted as required, but not according to any fixed schedule.

PENNSYLVANIA

Training Coordinator:

Tom White, Chief
TPL Section
Room 111
P. O. Box 2675
Harrisburgh, Pennsylvania 17105
(717) 782-6253

Pennsylvania's "TPL Resource Guide" was developed to assist the Income Maintenance Worker in identifying and recording TPL medical resources.

The first part of the guide lists several eligibility situations that are commonly encountered. For each of these situations, question areas are identified that could indicate the presence of third party medical resources (TPR). The type of potential TPR is also listed.

The second part of the guide instructs the income maintenance worker on medical resources such as Medicare, Blue Cross, and Blue Shield, CHAMPUS, private carriers, unlisted carriers, casualty and patient pay situations. Each group is described briefly. Included in this training is the necessary documentation for TPR recording, followed by the appropriate TPR codes for that group.

The "TPL Resource Guide" is used as a reference during the eligibility determination process.

SECTION IV

STATE TPL TRAINING

Medical Assistance
and
Third Party Liability Leaflet

SECTION IV - STATE TPL TRAINING #2

"Medical Assistance and Third Party Liability" Leaflet * ILLINOIS

The Illinois Department of Public Aid gives the attached leaflet to applicants for and recipients of Medical Assistance. The leaflet explains the TPL provisions and how those provisions impact upon the Medicaid recipient. For further information, please contact:

Ron Lowder
Illinois Department of Public Aid
TPL Section
100 South Grand Avenue East
Springfield, Illinois 62762
(217) 782-6765

MEDICAL ASSISTANCE AND THIRD PARTY LIABILITY

What Is Third Party Liability?

A third party is any person, insurance company, organization or program that has or may have a responsibility or liability to pay all or part of the cost of your medical care.

The Medical Assistance Program pays for most medical care costs when the care is not covered by a third party or when the third party will not pay the cost of care up to Department standards. The Green Card covers medical costs when no one else is legally responsible and able to pay. Some third party resouces are

1 Medicare

2 Railroad retirement and other retirement pension plans which provide health insurance coverage

3 Health insurance policies such as:

- private health insurance - an individual policy contract between a person and an insurance company,
- group health insurance - coverage for persons through an organization such as an employer, union, or fraternal or veteran's organization, or
- private or group health insurance carried by an absent parent, step-parent or grandparent

4 Workers' compensation: insurance coverage provided by an employer for work-related injuries

5 CHAMPUS (Civilian Health and Medical Program of the Uniformed Services): medical coverage for dependents of uniformed service personnel

6 Court orders requiring a separated or divorced parent to provide health insurance or to pay medical costs for a dependent

If you think you may qualify for a third party resource that you are not receiving, ask your caseworker where to apply.

ASSIGNMENT OF MEDICAL SUPPORT AND AGREEMENT TO COOPERATE

Illinois law provides that by applying for assistance, you assign to the Department of Public Aid your rights to medical support and payments for medical care. You also assign the rights of other persons for whom you are applying. The assignment means the

Department may keep medical support and payments for which you qualify as reimbursement for medical assistance paid on your behalf. The assignment lasts for the period of time that you receive assistance.

The agreement to cooperate means that you must:

- supply necessary information about your third party resources,
- obtain free health insurance coverage if it is provided by your employer or union for yourself and/or your dependents, and
- turn over to the Department payments that you receive for medical care.

If you fail to cooperate, you will not be eligible for medical assistance.

You may also be required to cooperate with the Child Support Enforcement Program and to establish paternity for a dependent child, when necessary. If you fail to meet these cooperation requirements, you will not be eligible for cash or medical assistance.

Other persons are not affected if you do not cooperate. Let your caseworker know if you have a good reason for not cooperating.

YOUR RESPONSIBILITIES

In addition to cooperating with the Department, you are to give hospitals, doctors, clinics and other providers of medical services information that they need to bill your third party resources. All resources that may cover your medical care must be billed to see if they will pay before the Department will pay. Report changes in your third party resources and in the persons who are covered so Public Aid knows who should be billed for your medical expenses.

THE DEPARTMENT'S RIGHT

Sometimes Public Aid pays a medical bill that a third party should have paid. When this happens, the Department has the right, by law, to collect its payment from the third party. The Department does not need your consent to get this payment.

SECTION IV

STATE TPL TRAINING

State TPL Training Videos

STATE TPL TRAINING VIDEOS

* CALIFORNIA
* NEW YORK
* OREGON

The States of Oregon, California, and New York have videos used in training eligibility workers. Training manuals/materials which complement the videos have also been developed. For further information, please contact:

Gerald B. Rohlfes
Department of Health Services
Recovery Branch, Suite 201
1250 Sutterville Road
Sacramento, CA 95822
(916) 445-0416

Kenneth Buzzard
Department of Social Services
Third Party Resources
P. O. Box 1935
Albany, New York 12201
(518) 474-9193

Steven Cloud
Adult and Family Services Division
Recovery Services Section
Public Service Building, Room 400
Salem, Oregon 97310
(503) 378-3729

SECTION V

STATE TPL FORMS

SECTION V - STATE TPL FORMS

ALABAMA	** IOWA
ARKANSAS	** MINNESOTA
** CALIFORNIA	** NEW JERSEY
** COLORADO	** OREGON
FLORIDA	** TENNESSEE
** ILLINOIS	** TEXAS
INDIANA	

1. Abstract - A critical phase in the cost avoidance of claims and recovery of Medicaid payments is the up front identification of liable third party resources. Indeed, the ultimate success of any TPL program and the reduction of Medicaid expenditures rests on the determination of a client's medical coverage beyond Medicaid. A State's systematic approach to the identification of TPL is a mandatory prerequisite to TPL program success. This systematic approach entails, as an initial step, the Medicaid caseworker's determination of possible TPL coverage during the eligibility or redetermination of the eligibility process. To facilitate this approach, States have developed and utilized various forms to identify and document third party resources. TPL forms in this section are representative of forms provided by many States. Although not all inclusive, we believe the forms in this section represent good examples of those which are being used to capture third party resource information or to notify recipients of their responsibilities of reporting third party resources.

   The categories of the forms are as stated below. Not each State is represented in each section.

   1. Medicaid TPL Intake
   2. Followup/TPL Identification
   3. Followup/TPL Identification Resulting from Data Match
   4. Casualty and Accident Questionnaires
   5. Medical Assistance Termination Notice
   6. IV-D/TPL Inquiry
   7. Health Insurance Premium
   8. Notice to Recipients

SECTION V

STATE TPL FORMS

1. Medicaid TPL Intake

ALABAMA MEDICAID AGENCY

This form is completed for nursing home applicants/recipients

(Point of Eligibility)

District Office Number _____

MEDICAL INSURANCE:

Do you have Medicare (Social Security Health Insurance)? ..... ☐ Yes ☐ No

What is your Medicare Number? _____

What is your Medicaid Number? _____

Do you have any other health or accident insurance policies? ..... ☐ Yes ☐ No
(This includes any accident, cancer, group, indemnity, C+ or other health insurance)

If Yes, do you, the applicant, pay the premium? ..... ☐ Yes ☐ No

If you have insurance which may cover any of your expenses, you must furnish insurance information to Alabama Medicaid Agency (DO NOT list Medicare, life or burial insurance).

_____ Name Applicant/ Recipient

_____ Social Security Number

_____ Address

_____ Zip

_____ Phone

Health Insurance Co.
Name and Address

1. _____

Policy Number _____

_____ Name of Policy Holder

Premium Amount _____

How often is premium paid? _____

2. _____

Policy Number _____

_____ Name of Policy Holder

Premium Amount _____

How often is premium paid? _____

3. _____

Policy Number _____

_____ Name of Policy Holder

Premium Amount _____

How often is premium paid? _____

4. _____

Policy Number _____

Premium Amount _____

How often is premium paid? _____

5. _____

Policy Number _____

Premium Amount _____

How often is premium paid? _____

If Group Health Insurance, Employer Name and Address

_____

Group Number _____

Premium Amount _____

How often is premium paid? _____

List only family members covered by above insurance who are also eligible for Medicaid:

Name	Company and Policy Number	Medicaid Number

Pa

ARKANSAS SOCIAL SERVICES DIVISION

THIRD PARTY RESOURCE WORKSHEET

CASEHEAD _____ CASE NUMBER _____

ADDRESS _____ SOCIAL SECURITY NUMBER _____

INSTRUCTIONS

Please read the questions below and see if they apply to your client. Answers should be printed in blanks or applicable answers checked.

1. Is any case member: ☐ Blind ☐ Disabled ☐ Over 65 ☐ Chronic Kidney Disease Patient

   Are they enrolled in: ☐ Medicare A and/or B Name(s) _____

2. Is any case member covered by PRIVATE HEALTH INSURANCE? If so, complete the following: *

   Case Member Names: _____

   Company Name: _____

   Address: _____

   Policy Numbers: _____
   (Group No.) (Individual No.)

3. Is any case member WORKING or a member of a LABOR UNION? If so, complete the following: *

   Name _____ Employer/Union _____

   Address of Employer/Union: _____

4. Is any case member, parent, absent parent, or spouse in the MILITARY? If so, complete the following:

   _____
   Name of Case Member Social Security Number

   Address and Branch of Service: _____

5. If there is a divorce or separation involved in this case, does the agreement or any court order require:

   ☐ Payments for Medical Care ☐ Payments for Health Insurance

   Is health insurance available through absent parent?

   Name: _____

   Insurance Company: _____

   Address: _____

   Policy Numbers: _____
   (Group No.) (Individual No.)

6. Has any case member been in an ACCIDENT requiring medical care? If so, Name: _____

   Accident Occurred: ☐ SCHOOL ☐ WORK ☐ PRIVATE PROPERTY ☐ AUTO ☐ COMMERCIAL PROPERTY ☐ OTHER

7. Do you have ADDITIONAL INFORMATION which might help identify THIRD PARTY LIABILITY?

   _____

   _____

*Use additional form for more than one policy or working case member

SS-662 (12/81)

ARKANSAS INSTRUCTIONS FOR

THIRD PARTY RESOURCE WORKSHEET

PURPOSE

Often clients eligible for Medicaid have a "third party resource," such as health insurance, which could be used to pay medical bills in place of Medicaid.

This form provides some "tip-off" questions for caseworkers to assist in uncovering these third party resources and a way to record this data for use by the Medical Assistance Section.

COMPLETION

1. Use this form when any client (new or reevaluation) qualifies for Medicaid.
2. You may read or paraphrase the questions.
3. Record only affirmative answers in the blanks provided. If there is no information, leave the space blank.
4. Attach to case record.
5. Supervisor: Route only if any affirmative answers provided.

ROUTING

When completed, send to:

Medical Assistance - TPL
8th Floor
Blue Cross Blue Shield Building
Little Rock, Arkansas

If the client provides all negative responses
DO NOT return or retain the form.

Recipient Health Resource Information
Medical Assistance Program

FORM MS-10

PLEASE PRINT—FOR MICROFILMING, FORM MUST BE FILLED OUT IN BLACK INK—DO NOT WRITE IN SHADED AREAS

IDENTIFYING INFORMATION

1. CASE NAME (Last, First)

2. HOUSEHOLD NUMBER
COUNTY | BASIC | SUFFIX

3. RESOURCE TYPE—STATE USE ONLY
- ☐ 1—Auto Insurance
- ☐ 2—Health Insurance
- ☐ 3—Workmen's Compensation
- ☐ 5—Other Insurance
- ☐ 6—Parent's Health Insurance

4. CASE ACTION
- ☐ A-Add
- ☐ D—Delete
- ☐ C—Change

HEALTH INSURANCE INFORMATION

5. POLICYHOLDER NAME (Last, First) AND ADDRESS (Street, City, State, Zip Code)

6. CARRIER ID NUMBER

7. POLICY NUMBER

8. GROUP NUMBER

9. COVERAGE BEGIN DATE — Month | Day | Year
COVERAGE END DATE — Month | Day | Year

10. INSURANCE COMPANY NAME

11. ADDRESS FOR SUBMISSION OF CLAIMS

12. EMPLOYER/GROUPHOLDER NAME AND ADDDRESS (Street, City, State, Zip Code)

13. RELATIONSHIP CODES — ENTER CODE NUMBER IN BOX
1—SELF 2—SPOUSE 3—SON 4—DAUGHTER 5—OTHER
First and last name, relationship code, and matching State ID numbers of covered household members

	NAME	REL CODE	STATE I.D.
A.		☐	
B.		☐	
C.		☐	
D.		☐	
E.		☐	
F.		☐	
G.		☐	
H.		☐	
I.		☐	

14. COVERAGE — STATE USE ONLY
- ☐ 05—Inpatient
- ☐ 10—Inp. Psych.
- ☐ 15—Outpatient
- ☐ 20—Skilled Nursing
- ☐ 25—Int. Nursing
- ☐ 30—Home Health
- ☐ 35—Practitioner
- ☐ 45—Lab & X-ray
- ☐ 50—Transportation
- ☐ 55—Drugs
- ☐ 60—FP
- ☐ 70—Supplies/DME
- ☐ 90—Dental
- ☐ 95—Practitioner/Psych.

AUTOMOBILE LIABILITY INSURANCE INFORMATION

15. POLICYHOLDER NAME (Last, First) AND ADDRESS (Street, City, State, Zip Code)

16. INSURANCE COMPANY NAME AND ADDRESS (Street, City, State, Zip Code)

17. CASE ACTION
- ☐ A—Add
- ☐ D—Delete
- ☐ C—Change

18. STATE I.D. NUMBER

19. STATE I.D. NUMBER

20. POLICY OR CONTRACT NUMBER

21. CARRIER I.D. NUMBER

22. COVERAGE BEGIN DATE — Month | Day | Year
COVERAGE END DATE — Month | Day | Year

SEND WHITE COPY TO:

Colorado Department of Social Services
Division of Medical Assistance
Appeals and Recovery Section
1575 Sherman Street
Denver, Colorado 80203

RETAIN CANARY COPY/Case Record

FORM NO. 10048 (REV. 5-87)

Third Party Subsystem Carrier File Date

Action Code
2

Carrier Identification
3 4 5 6 7 8

Card Code
1
1

Carrier Name
9

Carrier Street
39

Card Code
2
1

Carrier Office Suite
9

Carrier City
31

Carrier State
46

Carrier Zip Code
48

Carrier Telephone
53

Carrier Telephone Extension
63

Carrier Filing Limit
67

STATE OF FLORIDA
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES
Medical Resources Documentation (SunCom 278-2495)
1317 Winewood Blvd., Bldg. 3, Rm 405, Tallahassee, FL 32399-0700

A. PAYEE INFORMATION:

1 LAST NAME	2 FIRST NAME	3 MI	4 SEX	5 SOCIAL SECURITY NUMBER

6 CASE NUMBER	7 MEDICAID NUMBER	8 DIST	9 CNTY.	10 UNIT	11 PROG.	12 ACTION CODE

B. CASE TYPE 13 (check type)

AFDC		PMA	
FC		Intrastate	
MAO		Interstate	
Date Public Assistance Cancelled			
/ /			

C. ABSENT PARENT INFORMATION:

14 LAST NAME	15 FIRST NAME	16 MI	17 SSN

18 RESIDENCE ADDRESS	19 MAILING ADDRESS, if different
20 EMPLOYER	21 EMPLOYER'S ADDRESS

D. INSURANCE INFORMATION:

22 CARRIER CODE	23 POLICY NUMBER	24 POLICY EFFECTIVE DATES FROM / /	TO / /
25 NAME OF INSURANCE COMPANY			
26 ADDRESS OF CLAIMS OFFICE	27 CITY	28 ST	29 ZIP
		30A	

30 CHECK TYPE BENEFITS

___ 1. Basic Hospital Coverage	___ 7. Accident Only (non-Auto)	___ 13. Nursing Home Supplement
___ 2. Basic Medical	___ 8. Automobile	___ 14. Health Maintenance Org. (HMO)
___ 3. Basic Surgical	___ 9. Motorcycle – Passenger Accident	___ 15. Dental
___ 4. Basic Hospital/Medical/Surgical	___ 10. Specified Disease – Cancer	___ 16. CHAMPUS or CHAMPVA
___ 5. Hospital Indemnity	___ 11. Specified Disease – Heart	___ 17. Labor Union Trust/Welfare Plans
___ 6. Major Medical	___ 12. Medicare Supplement	___ 18. Continuous Care Contracts

E. TYPE OF POLICY 31 INDIVIDUAL ☐ GROUP ☐ IF "GROUP," COMPLETE FOLLOWING:

32 EMPLOYER OR GROUP MAINTAINING COVERAGE	33 GROUP NUMBER
34 GROUP ADDRESS	35 CITY / 36 ST / 37 ZIP
38 WHERE ARE CLAIMS FILED? Employer/Group ☐ Insurance Company ☐	

F. IS ABOVE LISTED PAYEE POLICYHOLDER? 39 YES ☐ NO ☐ IF NO, COMPLETE FOLLOWING:

40 POLICYHOLDER LAST NAME	41 FIRST NAME	42 MI	43 SOCIAL SECURITY NUMBER
44 POLICYHOLDER'S ADDRESS	45 CITY	46 ST	47 ZIP

G. INDICATE ALL INDIVIDUALS COVERED BY POLICY:

48 LAST NAME	49 FIRST	50 MI	51 RELATION CODE	52 MEMBER NO.	53 SOCIAL SECURITY NUMBER

H. COMMENTS: 54

Distribution of Copies: WHITE—Medicaid Third Party
YELLOW—Caseworker

HRS Form 1293A, Sep 86 (Replaces Jul 80 edition)

55 Caseworker's Signature and Phone Number

56 Date Signed

INSTRUCTIONS FOR COMPLETING HRS FORM 1293

MEDICAL RESOURCES DOCUMENTATION FORM

1. This form must be completed by the caseworker during eligibility determination and re-determination when a client eligible for Medicaid is covered by an insurance policy covering sickness, disease or injury. If more than one policy covers an individual, a separate form must be completed for each policy. Do not complete the form if the client has Medicare coverage only; the form is not intended to place Medicare coverage information on the Third Party File. Medicare information is obtained from Bendex.

NOTE: This form is not be be completed for SSI cases placed on the eligibility file. Remember that the data supplied on the form will be printed on the recipient's Medicaid ID card and used by medical providers to bill insurance companies.

2. HRS Form 1293 is a 2-part form: Form 1293-A and Form 1293-B. The forms are identical as to information contained on the form but are used in different circumstances:

a. HRS FORM 1293-A is a 2 part NCR form which is to be used when the caseworker is documenting a particular health or accident insurance policy for the first time.

b. HRS FORM 1293 B is the computer printed turnaround document. The Medicaid Third Party Unit in Tallahassee inputs into the Third Party Liability System information received on the HRS Form 1293-A. The computer printed HRS Form 1293-B is returned to the District to be filed in the case file after verification of the information with the insurance company. Caseworkers should indicate any changes to a policy by lining out incorrect information and writing in new information in red or blue ink on the HRS Form 1293-B itself and forward it to the Medicaid Third Party Unit. After verification of the information, a new 1293-B will be returned to the District caseworker.

3. Fill out the form as completely as possible. Detailed instructions follow #7.

4. The information should be printed in red or blue ink or typed (Form 1293A).

5. Forward completed original Form 1293-A or 1293-B with corrections and updates to:

Department of Health and Rehabilitative Services
ASFMAG, Medicaid Third Party Recovery Unit
1317 Winewood Boulevard
Building 3, Room 405
Tallahassee, FL 32399-0700.

6. Caseworkers can obtain the 1293A Forms through the district supply center. Districts can order the forms, as necessary, through Jacksonville warehouse (ASCAGJ).

7. Detailed Instructions for Completing HRS Form 1293 by item number as follows:

SECTION A	PAYEE INFORMATION
Items 1-3	LAST NAME, FIRST NAME, MIDDLE INITIAL - Enter name of individual to whom AFDC grant award is made or a MIC is issued (same as Item 11 on the Public Assistance Client Eligibility System (PACE); Grant Payee Name - individual to whom AFDC warrant or MIC is mailed).
Item 4	SEX - enter M for male and F for female for sex of individual in Items 1-3.
Item 5	SSN - Enter Social Security Number for the individual in Items 1-3.
Item 6	CASE NUMBER - Do not complete.
Item 7	MEDICAID NUMBER - 10 position numeric code. Enter Medicaid Number for individual in Items 1-3.
Item 8	DIST. - District Number - 2 position numeric code or 2 position numeric code with 1 position alpha code. For example - DISTRICT 1 = "01" DISTRICT 11 - "11" - DISTRICT 2A = 2A.
Item 9	CNTY - County Code. 2 position numeric code. Enter code for county of location. Same as Item 12 on the PACE. Refer to PACE manual for table of county codes.
Item 10	UNIT - For future use. Do not complete.
Item 11	PROG. - 3 position alpha-numeric code. The first position is alpha, the second and third are numeric. The alpha position identifies the category of aid, the numeric positions identify the specific program. Same as Item 34 on the PACE. Refer to PACE Manual for table of program codes.

Item 12 ACTION CODE - 1 position alpha code: A = Addition, C = Change, and D = Deletion.

A = Addition - Enter "A" when:

1. a new case or individual recipient is being added to the Recipient Eligibility File for the first time and insurance coverage was not previously reported on this form.

2. a recipient in an active case acquires insurance or new insurance for the first time.

3. a case is being reapproved after a period of more than 24 months and third party coverage is present.

C = Change - Enter "C" when:

1. original information documented is updated or corrected. Such changes should be made directly on HRS Form 1293-B, the computer turnaround document by lining out the incorrect information and writing the updated information in red or blue ink. If there are no changes to an insurance policy already documented, there is no need to take action to update the HRS Form 1293-B. Examples of changes include, but are not limited to:

   a. an individual is dropped from policy. Line out the individual dropped.

   b. an individual is added to a policy. Print the added individual's name.

NOTE - Do not line out an individual who loses Medicaid eligibility but is still covered by the policy since Medicaid will still pay claims for services provided during eligibility but received after eligibility is terminated. <u>This form is to be used only to indicate changes to insurance policies, not to Medicaid eligibility</u>.

2. special situation - a recipient in an active case acquires an additional insurance policy (use Form 1293-A and Action Code C in this case).

D = Deletions - USE ONLY IF ADVISED BY RECIPIENT THAT INSURANCE POLICY HAS BEEN TERMINATED AND INCLUDE THE DATE THE POLICY WAS TERMINATED. ELIGIBILITY WORKERS MUST <u>NOT</u> ACT ON DELETIONS OTHER THAN FORWARDING THE INFORMATION TO THE THIRD PARTY RECOVERY UNIT.

An individual is deleted from the Insurance Resource File when the individual loses Medicaid eligibility for 24 consecutive months. This information is obtained by the Medicaid Third Party Unit from reports produced from the Recipient Eligibility File.

SECTION B — TO BE COMPUTER GENERATED (VIA HRS FORM 860) BY CHILD SUPPORT ENFORCEMENT (OPCSE) -
CASE TYPE - Mark appropriate box for:
- AFDC - Aid to Families with Dependent Children
- FC - Foster Care
- MAO - Medical Assistance Only
- PMA - Public Medical Assistance
- Intrastate
- Interstate

also enter the date Public Assistance was cancelled by using a numeric code for month, date and year. Example, September 11, 1986 would be 09/11/86.

SECTION C — ABSENT PARENT INFORMATION - TO BE COMPLETED BY CHILD SUPPORT ENFORCEMENT (OPCSE).

Items 14-16 — LAST NAME, FIRST NAME, MIDDLE INITIAL - Enter name of absent parent.

Item 17 — SSN - Enter Social Security Number of absent parent.

Item 18 — RESIDENCE ADDRESS - Enter house, apartment or lot number, street, city, state and zip code of absent parent.

Item 19 — MAILING ADDRESS - Enter mailing address of absent parent only if different from residence address. If mail is sent in care of another individual, note that under Section H - Comments. Example = Section C-Item 19 is c/o Mr. John D. Doe.

Item 20 — EMPLOYER - Enter name of absent parent's employer.

Item 21 — EMPLOYER'S ADDRESS - Enter address of absent parent's employer.

PLEASE NOTE: COURT-ORDERED ABSENT PARENT. Determine if a court order exists which mandates that the absent parent maintain insurance coverage for his/her dependents. Indicate this in Section H - Comments. If details of policy are not known, complete Section C (boxes 14 through 21). Write comments as necessary in Section H. If the name and address of the employer are not known, complete all of Section C which is known.

If details of the policy are known, complete Section C and check the appropriate box(es) for the type of benefits available (Section D, No. 30).

SECTION D INSURANCE INFORMATION

Item 22 CARRIER CODE - 5 position numeric code. To be completed by Medicaid Third Party Unit (ASFMAG).

Item 23 POLICY NUMBER - Enter policy number, including any suffix or prefix. Should the number exceed 15 digits, enter the last 15 digits rather than the first 15 digits (i.e. digits to be dropped should be those at the beginning rather than the end of the policy number).

Item 24 POLICY EFFECTIVE DATES - Enter the date policy begins and expires by using a numeric code for day, month, and year. Example, enter 05/25/86 - 05/25/87 for a policy effective from May 25, 1986 through May 25, 1987. If the policy indicates it is "continuous until cancelled, enter "999999".

Item 25 NAME OF INSURANCE COMPANY. Enter full and complete name of Insurance Company. Abbreviating Ins. for Insurance and Co. for company is acceptable. NOTE - there are over 100 companies that begin their name with "American", 9 begin their name with "Travelers", 9 with "Hartford" etc. It is very important that you provide the full name.

Item 26 ADDRESS OF CLAIMS OFFICE - Enter the full address of the claim's office where claims for that policy would be filed. If a third party such as an adjusting firm handles all claims for that company, enter the address in items 26-29 and enter the name of the business in Section H. Example - "Claims handled by Crawford and Company at address in D26-29".

Item 30 CHECK TYPE BENEFITS. Indicate the type(s) of policy, plan, organization which provides benefits. These types do not refer to Medicaid. If you cannot determine the type of policy, attach a copy of the front page of the policy (if available) to the Form 1293 submitted to the Medicaid Third Party Unit.

1. Basic Hospial Coverage - usually includes room and board, X-rays, laboratory tests and other hospital expenses while confined as an inpatient.

2. Basic Medical Coverage - usually includes in-hospital medical services, consisting of Physician's services rendered.

3. Basic Surgical - includes coverage for surgical procedures and endoscopic procedures including pre-operative and post-operative care. Usually pays a scheduled limit for each code of operative procedure.

4. Basic Hospital/Medical/Surgical - usually includes coverage for all of the above (1, 2 and 3) in one policy.

5. Hospital Indemnity - provides daily benefits for confinement in hospital on a daily basis of not less than $10.00 per day. Benefits under this policy are usually made payable to the insured. However, Florida Statutes provide HRS with assignment rights. Therefore, HRS has full legal right to the benefits of the policy.

6. Major Medical - can be written on an individual (family) or as a group (employer) basis. It usually covers hospital, medical and surgical expenses and usually has a co-payment and deductible which are the responsibility of the insured.

7. Accident Only - covers for death, dismemberment, disability or hospital and medical care caused by an accident.

8. Automobile - three types of coverage are available. These coverages will be determined by the Third Party Unit during the verification process. Automobile policies sometimes have more than 15 digits. Because our computer file cannot hold in excess of 15 digits, please provide only the last 15 digits rather than the first 15 digits, when completing Item 23.

   *PIP of Personal Injury Protection (No-Fault insurance) provides 80% of reasonable expenses including but not limited to: medical, surgical, X-rays, dental, rehabilitative services, certain medical supplies, ambulance, hospital and nursing services, in the event of an automobile accident or while being struck as a pedestrian or bicyclist.

*Uninsured Motorist/Underinsured Motorist pays for 100% of the services above, but may pay additional benefits not paid above. Pays when a covered person is hit by an uninsured motorist (or one with very low limits of liability) after the covered person surpasses certain physical criteria.

*Medical Payments pays up to a limit of benefits chosen; usually $500.00, $1,000.00, $2,000.00, $5,000.00. Pays for necessary medical expenses and ambulance because of injury caused by an automobile accident or while struck as a pedestrian.

9. Motorcycle - Passenger Accident pays similar benefits to PIP, except that benefits are paid 100% up to a specified limit, and coverage may apply for the driver only, passenger only, or both.

10. Specified Disease - Cancer covers for cancer only, usually with a deductible. Pays for most medical services and generally accepted treatments for cancer only. These policies often do not pay for a specimen which test "benign".

11. Specified Disease - Heart covers for most conditions of heart disease. All "heart" claims will not be covered. Pays most medical services, however, few policies pay for transplants.

12. Medicare Supplement - Part A covers all eligible expenses for hospital not paid by Medicare, up to a limit. Includes deductible and coinsurance for room and board, general nursing, miscellaneous, hospital services, special care units, drugs, lab tests, X-rays, operating and recovery rooms, blood and prosthesis. Part B covers services of a physician, outpatient hospital, speech therapist, ambulance, physician administered test, medical supplies other than prescribed medication.

13. Nursing Home Supplement usually pays a stated amount per day for required skilled nursing service furnished immediately following an inpatient stay in the hospital. Coverage is offered for daily routine care, however, the policies are generally expensive.

14. Health Maintenance Organization (HMO) is a prepaid health care plan. Usually includes similar services as a major medical, but usually requires a small copayment and no deductible. May also include prescription drugs, vision and hearing, psychological and nutritional counseling.

15. Dental usually pays up to a scheduled limit for a variety of dental, peridontal and surgical procedures.

16. CHAMPUS/CHAMPVA - CHAMPUS (Civilian Health and Medical Program for Uniformed Services) covers a) family members of active duty personnel b) retirees, their spouses and unmarried children c) unremarried spouses and unmarried children of active duty or retired members d) spouses and unmarried children of reservists who are ordered to active duty 30 days or longer e) unremarried divorcees, without other health coverage, divorced after February 1, 1983, after at lest 20 years of marriage to a service member on active duty during those 20 years. CHAMPUS shares in most of the costs of care from civilian hospitals and doctors when care is not available through a military hospital or clinic. CHAMPVA (Civilian Health and Medical Program of the Veteran's Administration) shares the medical bills of families and survivors of certain veterans. Examples of CHAMPVA eligibility are: a) spouse or unmarried child of veteran with total, permanent disability resulting from service related injury b) spouse or unmarried child of veteran who died in line of duty.

17. Labor Union Trusts/Welfare Plans are individually written with benefits which have been negotiated or manuscripted for a particular labor union or employee group (such as IBM, Mobile Oil, General Electric, etc.). Generally, these policies provide greater coverage and benefits than a major medical policy.

18. Continuing Care Contracts - provides shelter, food transportation and either nursing care or personal services for residents. An entrance fee is usually charged which may be paid initially (Entry Fee) or monthly (maintenance fee). Residents may not be evicted because of their inability to pay until their prescheduled contractual termination date.

Item 30A COVERAGE TYPE CODE - Caseworkers, do not write in this space. This space is to be used by the Medicaid Third Party Unit (ASFMAG).

Illinois Department of Public Aid

HEALTH INSURANCE RESOURCE REPORT

SC

1. CASE LAST NAME	FIRST NAME	MI	2. CASE IDENTIFICATION NUMBER

A. HEALTH INSURANCE

3. INSURANCE COMPANY NAME	4. TPLC	5A. TPLC	5B. COV.	5C. LC

6. POLICYHOLDER-LAST NAME	FIRST NAME	MI	7. DATE OF BIRTH	8. SOCIAL SECURITY NUMBER

9. GRP	10. GROUP IDENT. NUMBER	11. CERTIFICATE/POLICY NUMBER	12. BEGIN DATE	13. END DATE	[illegible]	[illegible]

16. NAME OF (EMPLOYER, UNION, GROUP)

17. ADDRESS OF (EMPLOYER, UNION, GROUP)	18. CITY	19. STATE	20. ZIP

B. INSURED RECIPIENTS

FIRST	MI	LAST	RECIPIENT NUMBER	DATE OF BIRTH	BEGIN DATE	END DATE
21			22	23.	24.	25.
26.			27	28.	29.	30.
31			32.	33.	34.	35.
36.			37.	38.	39.	40
41			42	43.	44	45
46			47	48.	49	50.
51			52.	53.	54.	55

C. GENERAL INFORMATION

56. REMARKS:

57. LOCAL OFFICE USE ONLY

WORKER'S NAME _____

DATE _____

☐ ORIGINAL ☐ UPDATE

OFR COORDINATOR

CENTRAL OFFICE USE ONLY

58. FAIL ___ PASS ___ UPDATE ___	58. FAIL ___ PASS ___ UPDATE ___	58. FAIL ___ PASS ___ UPDATE ___
RDB ___ ADD ___ CHG ___ DEL ___	RDB ___ ADD ___ CHG ___ DEL ___	RDB ___ ADD ___ CHG ___ DEL ___
CIS ___ CHG ___ DEL ___	CIS ___ CHG ___ DEL ___	CIS ___ CHG ___ DEL ___

AUTHORIZATION FOR RELEASE OF INFORMATION

59. In order that the Department may make correct medical payments on my (our) behalf, I hereby authorize any health insurance company, employer, union or other health insurance sponsor to make available to the Department of Public Aid or any properly identified representative of said Department information regarding: benefit coverages or payments made under the terms of my (our) health insurance during my (our) term of public assistance. A photocopy of this authorization shall be as valid as the original.

_____ _____ _____ 19 ___

Signature Witness to Signature

DPA 1442 (R-5-85) THIS COPY TO: THIRD PARTY LIABILITY BUREAU OF COLLECTIONS IL 479-0072

HEALTH INSURANCE RESOURCE REPORT
INSTRUCTIONS FOR COMPLETION

This form must be completed for any health insurance policy which provides coverage for a client and/or members of an assistance unit. If there is more than one policy providing coverage, a separate form for each policy must be completed. If there are more than seven recipients covered, an additional form must be attached. When supplying any new information on previously reported coverage, submit as an update, following attachment instructions, and indicate change in "REMARKS" Section. Shaded areas are for central office use only.

Section A - Health Insurance

1. Enter case name, last, first and middle initial.
2. Enter 13-digit case identification number.
3. Enter the name of the insurance company.
4. Enter the 3-digit insurance company code. (Refer to Authorization Handbook item #79). If there is no code listed, enter 999.
6. Enter the name (last, first, middle initial) of the Policyholder. If the Caretaker Relative is the policyholder, enter "Same".
7. Enter the 6-digit birthdate of the Policyholder.
8. Enter the 9-digit Social Security Number of the Policyholder.
9. Answer Yes or No. If insurance is a "group" policy enter "Y" and complete Box 10 through Box 13 and Box 16 through Box 20.
10. If insurance is group, enter the group identification number. This number identifies the group and usually appears on the recipient's insurance company indentification card. (If insurance is individual, leave this box blank.)
11. Enter the certificate or policy number.
12. Enter the 6-digit date on which insurance coverage became effective, if known.
13. Enter the 6-digit date on which insurance coverage has lapsed, if known.
16. Enter the name of the organization (employer, union, group) holding the group policy.
17. through 20. Enter the street address, city, state, and zip code of the employer, union or group. (work location)

Section B - Insured Recipients - This section provides for names of seven members of the assistance unit who are covered under terms of the policy listed on this form. Enter only assistance unit members who are insured, including the Caretaker Relative, if insured.

21. Enter the first name, middle initial, and last name of the insured recipient.
22. Enter the 9-digit recipient identification number, if available.
23. Enter the 6-digit birthdate of the recipient.
24. Enter the 6-digit date on which insurance became effective.
25. Enter the 6-digit date on which insurance coverage has lapsed.
26. through 55. Complete as instructed above, for each recipient covered under this policy.

Section C - General Information - Complete each item as instructed below:

56. Enter any appropriate remarks.
57. Enter caseworker name, caseload number and date.

☐ Original - check ( ) this box if you are submitting this form for a newly approved application, a reinstated or an active case for which insurance information has not been previously reported.

☐ Update - check ( ) this box if form is submitted to change or correct previously submitted information, or if case is re-instated and insurance coverage, previously reported, is still in force or there is a new insurance, using a photocopy of the original DPA 1442 and following update instructions.

The OFR Coordinator or designee is to review and sign on line provided

58. This section is for CENTRAL OFFICE USE ONLY.
59. The policyholder, if available, should sign this authorization for release of information.

(REFER TO APPROPRIATE MANUAL CHAPTER FOR DETAILED INSTRUCTIONS)

Illinois Department of Public Aid

MEDICAL INSURANCE INQUIRY

Applicant _____ Date _____

Cat. _____ L.O. _____ Grp. _____ Basic _____

YOU MAY HAVE BOTH MEDICAL INSURANCE AND A GREEN CARD, BUT YOU MUST GIVE INFORMATION ABOUT MEDICAL INSURANCE THAT COVERS YOU AND PERSONS LISTED ON YOUR APPLICATION. IF YOU DO NOT GIVE THIS INFORMATION, YOU WILL NOT RECEIVE MEDICAL ASSISTANCE FOR YOURSELF.

ANSWER ALL OF THE QUESTIONS BELOW. BRING THIS FORM TO YOUR APPLICATION INTERVIEW. IF YOU OR YOUR FAMILY HAVE MEDICAL COVERAGE, ALSO BRING THE REQUESTED INFORMATION.

1. Do you or your spouse work or have either of you worked during the last 3 months? If either of you are/were covered by group health insurance through your job, bring: ( )yes ( )no

   1) the Social Security Number (SSN) of the employed person,
   2) group I.D. card,
   3) name and address of the employer, and
   4) name of the insurance company.

2. Are you or your spouse a member of a union? If either of you have medical coverage through your union, bring: ( )yes ( )no

   1) the SSN of the union member,
   2) group I.D. card,
   3) name and address of the union and the union local number, and
   4) name of the insurance company, if any.

3. Does your application include a child(ren) who has a parent not living with you? If the absent parent covers you or your child by group health insurance through work or a union, bring: ( )yes ( )no

   1) his/her SSN,
   2) group I.D. card,
   3) name and address of the employer,
   4) name and address of the union, if any, and the union local number, and
   5) name of the insurance company.

4. If you are under 19 years old (or under 23 and a full time student), do either of your parents work or belong to a union? If they include you in their group health insurance, bring: ( )yes ( )no

   1) your parent's name and SSN,
   2) group I.D. card,
   3) name and address of their employer,
   4) name and address of the union, if any, and the union local number, and
   5) name of the insurance company.

GO TO THE BACK OF THIS SHEET

DPA 267-TPL (N-6-86)

5. Is anyone in your home covered by school insurance? If yes, bring: ( )yes ( )no

   1) the name and address of the school, and
   2) name and address of the insurance company.

6. Are any of the following persons in the military or are they a military veteran: you, your spouse, your parents, your child's parent other than yourself? If you or your family is covered by CHAMPUS OR CHAMPVA, bring: ( )yes ( )no

   1) the name and SSN of the military person.

7. Do you or does anyone else pay for an individual health insurance policy for you or for anyone in your home? This would include an indemnity or income protection policy which pays a certain amount per day such as an American Association of Retired Persons (AARP) policy. If yes, bring: ( )yes ( )no

   1) the birthdate and SSN of the person named as the policyholder,
   2) the name and address of the insurance company, and
   3) the policy number.

8. If you or your spouse are retired, do you have health insurance coverage as a retiree or as a dependent or a survivor of a retiree? If yes, bring: ( )yes ( )no

   1) the SSN of the retired employee,
   2) group I. D. card,
   3) name and address of the employer,
   4) name and address of the union, if any, and the union local number, and
   5) name of the insurance company.

9. Have you or anyone in your home been in the hospital or seen a doctor in the past year? How was the bill paid? If it was paid by insurance, bring: ( )yes ( )no

   1) the name and address of the insurance company, and
   2) the policy number.

Your signature _____ Date _____

INDIANA

INTAKE INFORMATION

Recipient's name:_____

Recipient's Medicaid Number:_____

Recipient's Address (Street/Box):_____

City:_____

Recipient's Phone number:_____

Date of Accident:_____

Nature of Injuries:_____

_____

Other Parties Involved if Known:_____

Attorney's Name:_____

Attorney's Address:_____

Attorney's Phone Number:_____

Tortfeasor's Name:_____

Tortfeasor's Address_____

Tortfeasor's Attorney:_____

THIS INFORMATION WAS OBTAINED THROUGH:

Name:_____

Phone Number:_____

Address:_____

City:_____

INTAKE INFORMATION TAKEN BY:

Name:_____

Date Taken:_____

TPL V/20a

State of New Jersey

DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

THIRD PARTY LIABILITY INFORMATION

PLEASE PRINT
USE OTHER SIDE IF NECESSARY

INTAKE ___ CHANGE ___ COUNTY CODE _ _

1. CASE NAME _____ (LAST) (FIRST) MEDICAID NO. _ _ _ _ - _ _ _ _ _ _

2. IS THERE AN ABSENT PARENT IN THIS CASE? YES ___ NO ___

NAME _____ (LAST) (FIRST)

ADDRESS _____

_____

SSN _____

DATE OF BIRTH _____

CHILDREN _____ (LAST) (FIRST)

_____ (LAST) (FIRST)

_____ (LAST) (FIRST)

_____ (LAST) (FIRST)

3. IS A CASE MEMBER OR ABSENT PARENT EMPLOYED OR RECEIVING A PENSION? YES ___ NO ___

NAME OF CASE MEMBER OR ABSENT PARENT _____

NAME AND LOCATION OF PRESENT OR FORMER EMPLOYER OR UNION _____

_____

4. DOES A CASE MEMBER OR ABSENT PARENT HAVE HEALTH INSURANCE OR MEDICARE? YES ___ NO ___
ATTACH COPY OF FRONT AND BACK OF INSURANCE CARD(S) OR COMPLETE THE FOLLOWING:

NAME OF INSURED _____

GROUP/POLICY NUMBER _____

ID NUMBER _____

MEDICARE NUMBER _____

NAME AND ADDRESS OF INSURANCE CARRIER

_____

_____

_____

5. HAS ANY CASE MEMBER BEEN INVOLVED IN AN INCIDENT/ACCIDENT WITHIN THE PAST 5 YEARS FOR WHICH MEDICAL TREATMENT WAS OBTAINED? YES ___ NO ___

NAME OF INJURED PARTY _____ DATE OF INCIDENT/ACCIDENT _____

WHERE DID THE ACCIDENT TAKE PLACE?

__ AUTOMOBILE
__ HOME
__ PRODUCT LIABILITY
__ PLACE OF WORK
__ SCHOOL
__ MEDICAL MALPRACTICE
__ COMMERCIAL ESTABLISHMENT
__ PRIVATE PROPERTY
__ OTHER (IDENTIFY)

DESCRIBE THE INCIDENT/ACCIDENT, INCLUDING TYPE OF INJURY, ON THE OTHER SIDE.

WORKER'S NAME _____ (PLEASE PRINT) DATE _____

TPL-1 (1/89)

ADDITIONAL INFORMATION

2. ABSENT PARENT (CON'T)

NAME _____ (LAST) (FIRST)

ADDRESS _____

_____

SSN _____

DATE OF BIRTH _____

CHILDREN _____ (LAST) (FIRST)

_____ (LAST) (FIRST)

_____ (LAST) (FIRST)

_____ (LAST) (FIRST)

3. EMPLOYMENT OR PENSION (CON'T)

NAME OF CASE MEMBER OR ABSENT PARENT _____

NAME AND LOCATION OF PRESENT OR FORMER EMPLOYER OR UNION _____

_____

4. HEALTH INSURANCE (CON'T)

NAME OF INSURED _____

GROUP/POLICY NUMBER _____

ID NUMBER _____

MEDICARE NUMBER _____

NAME AND ADDRESS OF INSURANCE CARRIER

_____

_____

_____

NAME OF INSURED _____

GROUP/POLICY NUMBER _____

ID NUMBER _____

MEDICARE NUMBER _____

NAME AND ADDRESS OF INSURANCE CARRIER

_____

_____

_____

5. INCIDENT/ACCIDENT (CON'T)

DESCRIPTION OF INCIDENT/ACCIDENT: _____

_____

_____

_____

STATE OF OREGON
DEPARTMENT OF HUMAN RESOURCES
ADULT & FAMILY SERVICES DIVISION

MEDICAL RESOURCE REPORT

Attach COPY of Private Medical Card

Program	Branch	Case Number	Wkr. ID

Case Name

1 Private Insurance (Circle benefits)

1. Major Medical
2. Drug Coverage
3. Dental Coverage
4. Visual Coverage
5. Hospital Only
6. CHAMPUS Coverage
7. CHAMPVA Coverage
8. Surgery Only Coverage
9. Cancer Only Coverage
10. Accident Only Coverage
11. Health Maintenance (HMO)
12. Medicare Supplement
13. Medicare-Part A-Hospital
14. Medicare-Part B-Physician
15. Veterans
16. Other:
17. None

Medicare Benefit #_____

start date _____ end date _____

Veteran's Benefit # _____

start date _____ end date _____

Service Disability
- ☐ More than 50%
- ☐ Less than 50%
- ☐ Aid & Attendance
- ☐ Other

2 Absent Parent

Does an absent parent pay medical bills or provide medical coverage ☐ yes ☐ no

3 Central Office Use

Carrier Code	Client Co-payment	Coverage Code	Premium (OHI) Pmt.

4 Private Health Insurance Information

Policy holder's name: _____

Social Security #: _____

Group/Plan #: _____

Policy/Identification #: _____

Coverage through: ☐ Work ☐ Union ☐ Absent Parent ☐ Other

Name of Insurance Company: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Mail bills to: ☐ Insurance Company ☐ Union ☐ Work ☐ Other

5 Prime

Persons Covered	Private Coverage #'s circled in #1	start date	end date	premium

6 Division Health Plans

☐ Health Maintenance Organization (HMO)

☐ Physician Care Organization (PCO)

Name _____

☐ Dental Care Organization (DCO)

Name _____

begin _____ end _____

Comments

Date

CASE RECORD

AFS 1151 (Rev. 1/89)

Instructions for Completion of the AFS 415H

CASE NAME, PROGRAM, COST CENTER, CASE NUMBER AND WORKER ID - Enter information

1. PRIVATE HEALTH INSURANCE BENEFITS

   A. Circle all private health insurance benefits which currently cover the client or any eligible member of the grant. If other is circled, describe.

   B. Medicare Benefits: Enter complete Medicare benefit number, the date Medicare benefits become effective, or the date Medicare benefits ended (if applicable) when deleting coverage.

   C. Veteran's benefits: Enter complete Veteran's benefit number, the date Veteran's medical benefits became effective, or ended when deleting coverage. Enter the "type/ percent" of service disability.

2. ABSENT PARENT RESPONSIBILITY - Check "yes" or "no"

3. CENTRAL OFFICE USE -- FOR CENTRAL OFFICE STAFF ONLY

   A. CARRIER CODE: Enter four (4) digit carrier code for client's private insurance.
   B. CLIENT CO-PAYMENT: Enter the dollar amount of client co-payment for private insurance.
   C. COVERAGE CODE: Enter coverage code(s) for client's private insurance.
   D. PREMIUM (OHI) AMT: Enter the dollar amount listed in "Need OHI" field on CMS3.

4. POLICY HOLDER'S INFORMATION FOR PRIVATE INSURANCE

   A. Enter the policy holder's full name and social security number as it appears in the insurance benefits records.
   B. Enter the full name and address of the private health insurance company.
   C. Enter the private insurance group/plan number and the policy holder's private insurance ID number.
   D. Mark the appropriate box to indicate who provides coverage. (If coverage is through a union or employer, list the full name and address of the union or employer in the comments section.)
   E. Mark the appropriate box to indicate where medical bills should be mailed.

   NOTE: If client has more than one private insurance coverage, attach additional 415H forms and complete this

5. PRIME #, PERSONS COVERED & PRIVATE COVERAGE

   A. Enter the prime number and full name for each eligible member of the household in the grant.
   B. List the circled number(s) from the Private Health Insurance section of the form that applies to each person listed. If the person has more than one type of coverage, list all numbers that apply.
   C. Enter the date private health insurance benefits began for each individual.
   D. If private insurance coverage stops, enter the date that coverage ends for each individual.
   E. Enter the monthly premium amount paid by the client for private insurance coverage, if any.

6. DIVISION HEALTH PLANS - List the client's choice of prepaid managed health plan. (DCO) Dental Care Organization coverage must be sent to the AFS Health Insurance Group.

COMMENTS - Enter comments if the information listed in another part of the form could be confusing or if further explanation or detail of coverage is needed. If enrollment in a PCO/HMO is delayed, note in comments area.

ATTACH A COPY OF CLIENT'S PRIVATE MEDICAL INSURANCE CARD TO THE 415H

RSS THIRD PARTY RECOVERY UNIT
378-2516

SECTION V

STATE TPL FORMS

2. Followup/TPL Identification

HRS

TO: SUPPLEMENTAL SECURITY INCOME (SSI) RECIPIENTS

FROM: STATE OF FLORIDA, DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

SUBJECT: MEDICAL INSURANCE INFORMATION

When you applied for "SSI" your contact was with the Social Security Administration, an agency of the Federal Government. At that time, you provided information to the Federal Government so that they could determine your eligibility for "SSI".

When you were approved for "SSI" (gold colored monthly check), you became eligible for medical assistance (also known as Medicaid). Since Medicaid is administered by the State of Florida, not by the Federal Government, and we may not have had the opportunity to talk to you, it is necessary for us to obtain some information to better serve your medical needs.

The information requested at the bottom of this letter is needed to help process claims submitted to us when you receive services by hospitals, doctors, pharmacies, nursing homes, etc. It will ensure that they received correct payment for providing you medical services.

The information will NOT affect your eligibility for Medicaid but will help us in better serving you. It will be used for our department's use only and will be kept confidential.

If you have health insurance other than your Medicaid or Medicare coverage, please fill out the questionnaire as completely as possible and return this letter to us within 5 days of receipt. This questionnaire provides space for information on one health insurance policy. If you have more than one health insurance policy, please provide us with information about the second policy on a plain sheet of paper and enclose it with this questionnaire. For your convenience, fold this letter to form an envelope with the postage free return on the outside. The instructions on the back give specific directions concerning fold lines which will aid you in returning this questionnaire. Please use the gummed edge to seal the questionnaire; do not use staples or any other object for this purpose.

MEDICAL INSURANCE QUESTIONNAIRE

1. DO YOU HAVE ANY HEALTH INSURANCE (other than your Medicaid or Medicare coverage)? ___Yes ___No
2. IF YOU ANSWERED "NO" TO QUESTION 1, DO NOT COMPLETE THIS FORM AND DO NOT RETURN IT.
3. IF YOU ANSWERED "YES" TO QUESTION 1, PLEASE COMPLETE THE FOLLOWING AND RETURN.

PRINT Your Full Name (Last) _____ (First) _____ (Middle Initial) ___

Your Medicaid Number (same I.D. number that is on your green and white Medicaid I.D. card) _____

Insurance Company's Name _____

Policy Number _____ Effective Dates of Policy: from ___/___/___ to ___/___/___

What types of coverage does this policy provide? (check appropriate types)

___1. Basic Hospital
___2. Basic Medical
___3. Basic Surgical
___4. Basic Hospital/Medical/Surgical
___5. Hospital Indemnity
___6. Major Medical
___7. Accident Only (non-auto)
___8. Automobile PIP
___9. Specified Disease – Cancer
___10. Medicare Supplement
___11. Nursing Home Supplement
___12. HMO (non-Medicare)
___13. Dental
___14. Champus or ChampVA
___15. Court Ordered Ins.–Absent Parent

Weekly or monthly income while in hospital _____

Policyholder's Name and Address, if not you:

Name _____

Address _____

City _____ State _____ Zip _____

Is this policy through your employer or group (such as labor union)? ___Yes ___No If "yes", please complete the following:

Name of Employer or Group _____ Contract or Group Number _____

Address _____

City _____ State _____ Zip _____

Signature _____ Date Signed _____ Your Phone No. _____

HRS Form 1297, Mar 86 (Replaces Feb 83 edition)

Kathleen Kustra
Director

Illinois Department of Public Aid

Jesse B. Harris Building
100 S. Grand Avenue East
Springfield, Illinois 62762-0001

Attention: Patient Accounts Manager

PATIENT'S NAME:
RECIPIENT NUMBER:
SOCIAL SECURITY #:
DATE OF BIRTH:

Dear Sir or Madam:

On a recent credit adjustment form, a third party payment source was reported for the above referenced patient.

The Department of Public Aid is not aware of this insurance coverage and would like your assistance in providing information for our files. Please supply whatever information you have available and provide a copy of the insurance carrier's Explanation of Benefits form.

1) INSURANCE COMPANY NAME:

_____

2) POLICYHOLDER/EMPLOYEE _____ SOCIAL SECURITY #: _____

3) POLICY NUMBER: _____ GROUP NUMBER: _____

4) BILLING ADDRESS (WHERE CLAIMS ARE SENT FOR PAYMENT):

_____

_____

_____

_____

APA 2453A

5) NAME AND ADDRESS OF EMPLOYER:

_____

_____

_____

6) OTHER:

_____

_____

_____

Please return this letter with the Explanation of Benefits form within 30 days from the date of this letter. A self-addressed stamped envelope is enclosed for your convenience. If you have questions, please contact the Third Party Liability Section at (217) 785-1631.

Sincerely,

Manager
Third Party Liability Section

Enclosures

SECTION V

STATE TPL FORMS

3. Followup/TPL Identification Resulting From Data Matches

This form is computer generated from a data match with the certifying agency for ADC.

ALABAMA MEDICAID AGENCY
2500 FAIRLANE DRIVE
MONTGOMERY, ALABAMA 36130

DATE

J. MICHAEL HORSLEY
COMMISSIONER

MEDICAID #
P & S COUNTY #

RE: INSURANCE THROUGH

YOU HAVE REPORTED TO THE DEPARTMENT OF HUMAN RESOURCES THAT YOU AND/OR THE PERSONS LISTED BELOW ARE NOW OR HAVE BEEN COVERED BY HEALTH INSURANCE THROUGH THE COMPANY LISTED ABOVE. PERSONS ELIGIBLE FOR MEDICAID MAY ALSO BE COVERED BY HEALTH INSURANCE; HOWEVER, INFORMATION REGARDING THEIR INSURANCE MUST BE REPORTED TO THE MEDICAID AGENCY.

IN ORDER TO UPDATE OUR RECORDS PLEASE COMPLETE THE FOLLOWING EVEN IF YOUR INSURANCE ENDED WITHIN THE PAST 12 MONTHS.

1. LIST YOUR POLICY NUMBER_____ AND POLICYHOLDER'S NAME_____ FOR THE HEALTH INSURANCE CARRIED THROUGH THE COMPANY LISTED ABOVE.

2. ARE YOU COVERED BY ANY OTHER HEALTH INSURANCE? YES____NO____
   (DO NOT LIST MEDICARE, BURIAL, LIFE, OR CAR INSURANCE)
   IF YES, GIVE NAME OF COMPANY:_____,

   ADDRESS:_____,

   POLICY NUMBER:_____,

   POLICYHOLDER:_____.

3. TELEPHONE NUMBER WHERE YOU MAY BE REACHED BETWEEN 8:00 AM. AND 5:00 PM._____

PLEASE RETURN THIS INFORMATION, WITHIN TEN (10) DAYS, TO THE ALABAMA MEDICAID AGENCY, THIRD PARTY SECTION, 2500 FAIRLANE DR., MONTGOMERY AL 36130. FAILURE TO DO SO COULD JEOPARDIZE YOUR PRESENT OR FUTURE MEDICAID ELIGIBILITY. IF YOU HAVE QUESTIONS, YOU MAY CALL US AT 277-2710, EXTENSION 283 AND ASK FOR THE PARS CLERK.

SINCERELY,
KAY M. KEESHAN
ADMINISTRATOR, THIRD PARTY SECTION

This form is computer generated as a result of a IV-D data match.

ALABAMA MEDICAID AGENCY
2500 FAIRLANE DRIVE
MONTGOMERY ALABAMA 36130

J. MICHAEL HORSLEY
COMMISSIONER

SS # OF AP DATE

YOUR DEPENDANT (S) LISTED BELOW IS (ARE) ELIGIBLE FOR MEDICAID BENEFITS. FEDERAL REGULATIONS STIPULATE THAT MEDICAID IS THE LAST PAYOR OF MEDICAL EXPENSES INCURRED BY THOSE ELIGIBLE FOR MEDICAID, CONSEQUENTLY, THIS AGENCY HAS THE RESPONSIBILITY OF IDENTIFYING ANY RESOURCE AVAILABLE TO PAY FOR THEIR MEDICAL CARE. ONE SUCH RESOURCE IS HEALTH INSURANCE. YOU ARE URGED TO PROVIDE HEALTH COVERAGE FOR YOUR MEDICAID-ELIGIBLE DEPENDANTS AND, IF YOU DO NOT CARRY SUCH COVERAGE YOU ARE REQUESTED TO OBTAIN SUCH COVERAGE AND NOTIFY THIS OFFICE BY FURNISHING THE NAME, ADDRESS AND POLICY NUMBER OF YOUR INSURANCE, DEPENDANT (S) COVERED, THEIR MEDICAID NUMBER AND EMPLOYER INFORMATION.

TO ASSIST US IN COMPLETING YOUR DEPENDANT'S RECORDS, PLEASE COMPLETE THE FOLLOWING AND RETURN THIS LETTER TO THE ABOVE ADDRESS WITHIN TEN(10) DAYS:

NAME OF YOUR EMPLOYER:_____

ADDRESS OF YOUR EMPLOYER:_____
DO YOU CARRY HEALTH INSURANCE ON ANY OF THE BELOW-NAMED DEPENDANTS?
YES___ NO___ IF YOU HAVE ANSWERED YES, COMPLETE THE FOLLOWING:

NAME OF INSURANCE COMPANY:_____

ADDRESS:_____

POLICY NO.:_____POLICYHOLDER:_____
IS THIS INSURANCE CARRIED THROUGH YOUR EMPLOYER: YES___ NO___.
IF YOU HAVE ANY QUESTIONS, YOU MAY CALL 277-2710, THIRD PARTY SECTION, AND ADVISE YOU ARE CALLING IN REFERENCE TO LETTER 006-87.

SINCERELY,
(MRS.) KAY M. KEESHAN
ADMINISTRATOR, THIRD PARTY SECTION

MEDICAID-ELIGIBLE CHILDREN COVERED:

CHILD'S NAME	MEDICAID #	CASE NUMBER #

Susan S. Suter
Director

Illinois Department of Public Aid

Jesse B. Harris Building
100 S. Grand Avenue East
Springfield, Illinois 62762-0001

ATTN: Insurance Verification Section

NAME:
DOB:
SS#:
CASE #:

Dear Sirs:

The Illinois Department of Public Aid is required by law to determine what resources are available to Public Aid program participants that may be responsible, in whole or in part, for payment of their medical expenses. The Department's Medical Assistance Program is to pay for medical services only after all other liable parties have paid to the extent of their liability. Program participants may have group health insurance benefits through their own employment or may be covered as a dependent through a responsible relative's employment.

The Department has received information indicating the above individual has health insurance coverage through your organization. In order that we may determine what health insurance benefits are available to the above referenced individual and/or dependents, we ask that you complete Part A or Part B of the questionnaire, as indicated, on the reverse side of this letter. Even though insurance coverage may now be terminated, the information requested is essential to our determination of liability for previous medical services.

We have enclosed a self-addressed stamped envelope for your convenience. The disclosure of this information to the Department without written authorization is allowed under Subsection P of Section 1014 of the Illinois Insurance Information and Privacy Protection Act.

Thank you for your cooperation.

Sincerely,

Ronald D. Lowder
Third Party Liability Manager
Bureau of Collections
217-785-9741

TPL/COU/LM

(SEE REVERSE SIDE)

PPA 2453

Complete PART A _____ Group Coverage PART B _____ Individual Coverage

PART A GROUP COVERAGE ONLY

1. Name of Insured _____ SSN _____
2. Name of Your Group Insurance Carrier _____
3. Group # _____ Insured's Certificate # _____
4. Date Insured's Coverage Began _____ Date Terminated _____
5. Are Dependents Covered? YES _____ NO _____
6. If YES Please List Names and Dates of Coverage

NAME _____ BEGIN DATE _____ END DATE _____
NAME _____ BEGIN DATE _____ END DATE _____
NAME _____ BEGIN DATE _____ END DATE _____
NAME _____ BEGIN DATE _____ END DATE _____
NAME _____ BEGIN DATE _____ END DATE _____

7. WHERE SHOULD CLAIMS BE MAILED? _____
8. Contact Person Who Will Verify Coverage _____
   Telephone Number for Contact Person _____
9. Does Coverage Include the Following Benefits:
   Prescriptions _____? Dental _____? Visual _____?
10. Has Your Company Changed Insurance Carriers Within the Last Two Years?
    YES _____ NO _____
    If YES, Please Complete the Following:

    Name and Address of Previous Insurance Carrier _____
    Date Previous Group Coverage Began _____
    Date Previous Group Coverage Ended _____
    Previous Carrier Group Number _____

PART B INDIVIDUAL COVERAGE ONLY

1. Name of Insured _____ SSN _____
2. Certificate/Policy Number _____
3. Date Coverage Began _____ Date Terminated _____
4. Are Dependents Covered? YES _____ NO _____
   If YES, Please List Names and Effective Dates of Coverage

NAME _____ BEGIN DATE _____
NAME _____ BEGIN DATE _____
NAME _____ BEGIN DATE _____
NAME _____ BEGIN DATE _____
NAME _____ BEGIN DATE _____

5. Type of Policy:

Major Medical _____ Accident Only _____
Hospitalization _____ Hospital Indemnity _____
Medicare Supplement _____ Cancer Only _____
Other _____

REMARKS: _____

SECTION V

STATE TPL FORMS

4. Casualty and Accident Questionnaires

INSURANCE/ACCIDENT QUESTIONNAIRE

This form is computer generated as a result of claims processing edits when trauma codes or unknown TPL resources are indicated.

ALABAMA MEDICAID AGENCY
2500 Fairlane Drive
Montgomery, AL 36130

Medicaid #.
Date of Service.
ICN:
Letter Code:

Medicaid has paid for medical care you received on the above date. You may have health insurance or this care may have resulted from an injury. The following information is needed to determine if another source should pay your medical bill. Please answer the questions on both sides of this letter and return it to us within ten (10) days. FAILURE TO DO THIS COULD CAUSE YOU TO LOSE YOUR MEDICAID FOR UP TO ONE YEAR. Please use the enclosed stamped, addressed envelope to return this form. If you have questions, please call the Alabama Medicaid Agency and ask for the Third Party Section, (205) 277-2710.

SECTION I

Are you covered by cancer, accident, indemnity, group or individual health insurance other than Medicaid or Medicare? YES ____ NO ____

Name & Address of Insurance Company _____

_____

Policy # _____ Policyholder _____

Is this through an employer? YES ____ NO ____

Employer's name, address & telephone number: _____

_____

School name & address if school insurance: _____

_____

SECTION II

A. Were you treated on the above date because of an illness? YES ____ NO ____

If yes, state nature of illness _____

Were you treated on the above date because of an injury/accident? YES ____ NO ____
If you were treated because of an injury, check the type accident/injury:

Auto or other moving vehicle	____	Date of Injury _____
Assault (beating, rape; shooting, etc.)	____	Date of Injury _____
On the Job Injury	____	Date of Injury _____
Injury at Home	____	Date of Injury _____
Injury at School	____	Date of Injury _____
Other _____ (Specify type)	____	Date of Injury _____

B. Describe how your injury occurred _____

C. Have you retained an attorney as a result of this injury? YES ____ NO ____

Name and address of Attorney _____

Has suit been filed? YES ____ NO ____ Did you get a settlement? YES ____ NO ____

D. Did accident involve a moving vehicle? YES ____ NO ____

Was it a(n). Auto ____ Motorcycle ____ Bus ____ Other _____ (Specify) ?

Were you a: Driver ____ Passenger ____ or Pedestrian ____?

Name and address of all drivers of vehicles _____

E. Did injury result from assault, malpractice? YES ____ NO ____

Name and address of person who injured you: _____

F. Did injury occur at work? YES ____ NO ____

Name and address of your employer: _____

Employer's telephone number: _____

G. Did injury occur on private property (store, school, neighbor's home, relative's home, business, etc.) YES ____ NO ____

Name and address of business, school, store, or homeowner where injury occurred: _____

H. If injury/accident was caused by another person or on someone else's property, did they have insurance (car, homeowner's or other liability insurance)? YES ____ NO ____

Name and address of insurance company: _____

Policy Number _____ Policyholder _____

SECTION III

Telephone number where you can be reached between 8.00 and 4:30: _____

AUTHORIZATION AND ASSIGNMENT

I authorize any holder of medical or other information about me to release information needed for this or a related Medicaid claim to Alabama Medicaid Agency, and I authorize the further release of any such information to any other parties who may be liable for any of my medical expenses. I hereby assign to Alabama Medicaid Agency all claims against third parties, including tort-feasors and insurance companies, who may be liable for any of my medical expenses to the extent that such expenses are paid by Medicaid; I also assign all rights in any settlement made by me and arising out of any claim of which this is a part to the extent of medical expenses paid by Medicaid, whether or not a portion of such settlement is designated as being for medical expenses. Any such funds received by me shall be paid to Alabama Medicaid Agency. I permit a copy of this authorization to be used in place of the original.

_____ Recipient signature (or parent if minor) _____ Date

IMPORTANT: CONTACT THE ACCIDENT UNIT, THIRD PARTY SECTION, ALABAMA MEDICAID AGENCY, BEFORE YOU SIGN ANY RELEASE RELATING TO ANY ACCIDENT!

Mail To: Medicaid Third Party Liability Unit
Attention: Intake
P. O. Box 6004
Indianapolis, Indiana 46206-6004

REPORT OF CASUALTY / ACCIDENT CASE

County _____ Caseworker _____ Telephone _____

FURNISH ALL APPROPRIATE INFORMATION:

SECTION I

A: Recipient Information

Eligibility Date / /

Recipient Name Last	First	Middle Initial	Medicaid #
Date of Loss (Accident / Injury)			Date Discharged from Medical Care
Nature of Injuries			

DESCRIPTION OF ACCIDENT / INJURY (Include police report if possible) Is there a malpractice suit involved? ☐ Yes ☐ No

NAMES OF PROVIDERS TREATING THE PATIENT FOR ACCIDENT-RELATED INJURIES (INCLUDE DATES, IF KNOWN)

B: Recipient Attorney

Is the recipient representated by an Attorney? ☐ Yes ☐ No If yes, complete the next section.

Attorney's Name			Attorney's Firm's Name	
Address	City	State	Zip	Phone Area Code

C: Settlement Information

Has there been a settlement? ☐ Yes ☐ No Amount: $_____ Has the case been filed in court? ☐ Yes ☐ No

Name of Court	Judge	Cause Number	Hearing Date

D: Additional Recipient Information

Were other recipients injured in the accident? ☐ Yes ☐ No
If yes, list the names and Medicaid numbers of the other involved recipients.

NAME	MEDICAID NUMBER
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

(Continued on Reverse Side)

356-104 (05-

INDIANA

INFORMATION CONCERNING THE THIRD PARTY

COMPLETE ALL APPROPRIATE SECTIONS.

SECTION II:

A.

Name of 3rd Party(s)

Address | City | State | Zip

If an attorney has been retained:

Name of Party Retaining the Attorney | Attorney's Name | Attorney's Firm's Name

Address | City | State | Zip | Phone Area Code

B.

Name of Insured (if different than the 3rd party)

Address | City | State | Zip | Insured's SS#

C.

Name of Insurance Company

Address | City | State | Zip | Phone Area Code

Has liability been accepted? ☐ Yes ☐ No | Date | Insurance Policy # and / or Claim #

Name of Claims Adjustor | Name of Claims Office

Address | City | State | Zip | Phone Area Code

D. If other Third Party(s) are involved, be sure to attach additional pages using this format.

SECTION III:

A. If this was an on-the-job accident, complete the following:

Name of Employer | Address | City | State | Zip | Phone Area Code

Employee's Name | SS# | Employee I.D. # and / or Clock # | Dates of Employment: From _____ to _____

B. Has the case been filed with the Industrial Board? ☐ Yes ☐ No If "yes", please complete the following:

Name of the Insured | Name of Carrier | Cause Number | Hearing Date

Address | City | State | Zip | Phone Area Code

Insurance Policy # and / or Claim # | Name of Claims Adjustor | Name of Claims Office

Address | City | State | Zip | Phone Area Code

C. Employer Attorney

Attorney's Name | Attorney's Firm's Name

Address | City | State | Zip | Phone Area Code

ACCIDENT QUESTIONNAIRE

Dear Medicaid Recipient or Representative:

Medicaid has received a claim for services which were the result of an accident. Answer the questions on this form so that Medicaid can determine if another person or insurance company may be responsible for paying this bill.

Answer all the questions which apply to you. If a question does not apply, write "NA" (not applicable) in the space provided. If you do not have the information that is needed, please get it.

If you have any questions, please contact your Medicaid caseworker or the TPL Unit. This form must be returned to Medicaid within 14 days. No postage is required.

Sincerely,

INDIANA

AQ - ACCIDENT QUESTIONNAIRE

74e

ANSWER THE QUESTIONS FOR EACH PART OF THE FORM

Part A

1 - Be sure your name, address, and Medicaid number are correct as printed. If not, please make corrections on the label at the right.

Recipient Name
Address
City, State, Zip
PCN
ICN

2 - If you have not had an accident, check here ___
DO NOT ANSWER THE REST OF THE QUESTIONS, GO TO PART C AT END.
If you have been involved in some type of accident, fill in the information requested below.

3 - Date of accident _____
4 - What type of accident was this? (Circle one)

accident was at home, school, or on someone else's property	accident was at work	accident involved a vehicle
Answer "HOME OR OTHER" questions in A below.	Answer "WORK" questions in B below.	Answer "VEHICLE" questions in C below.

HOME: or OTHER

a) If the accident happened in your home or apartment, do you have a home owner's policy? Yes_____ No_____

If yes, give name and address of insurance company. _____

b) If the accident occurred on someone else's property, where did the accident occur? (for example, at a neighbor's home, a store, a school, etc.) Give name of owner or manager, store, or school, etc. _____

Address _____

Give name and address of person's, store's or school's, insurance company, if known _____

WORK:

a) Name of employer, including plant/office/store location._____

b) Did you report the accident to your employer as having happened at work? Yes_____ No_____

c) Has a Worker's Compensation Claim been filed? Yes_____ No_____

VEHICLE:

a) Were you a driver_____, passenger_____, or pedestrian_____?

b) If you were the driver, give your vehicle insurance company name and address. _____

c) If you were a passenger or pedestrian, give driver's name, address, and social security number. _____

Give driver's insurance company's name and address

d) Where did the accident occur? Street(s) _____
City _____ County _____

mak30/4e

Part B

1. Have you hired an attorney or has an attorney contacted you? Yes_____ No_____

   If yes, give attorney's name, address, and phone number. _____

   _____

2. Have you been contacted by an insurance company about the accident?
   Yes_____ No_____

   If yes, give policy holder's name. _____ policy #_____

   Insurance company's name and address_____ agent's name, address, a
   _____ phone # _____

3. Have you received a settlement or any other money for your injuries? _____
   Yes_____ No_____

   If yes, give amount. _____

   Who issued the money to you? _____

Part C

1. Name of person completing this form. _____

2. Give phone number where you can be reached during the hours 8:00 a.m. to 5:00 p.m. Monday through Friday. _____

3. Other comments or information regarding accident. _____

   _____

Part D

_____ _____
Signature of Person Completing Form Date

THIS FORM MUST BE RETURNED TO MEDICAID. POSTAGE IS PROVIDED.

Fold this form so the Medicaid name and address shows, seal the flap, and put in a mailbox.

INDIANA

74g

TRAUMA QUESTIONNAIRE

Dear Medicaid Recipient or Representative:

Medicaid has received a claim for services to you which may have been the result of an accident. Please answer the questions on this form so that Medicaid can tell if another person or another insurance company may also be responsible for paying this bill.

Answer all of the questions which apply to you. If a question does not apply, write "NA" (not applicable) in the space provided. If you do not have the information that is needed, please get it.

If you have any questions, please contact your Medicaid caseworker or the TPL Unit. This form must be returned to Medicaid within 14 days. No postage is required.

Sincerely,

wsk30/12a

INDIANA

TQ - TRAUMA QUESTIONNAIRE

74h

ANSWER THE QUESTIONS FOR EACH PART OF THE FORM

Part A

1 - Be sure your name, address, and Medicaid number are correct as printed. If not, please make corrections on the label at the right.

Recipient Name
Address
City, State, Zip
PCN
ICN

2 - Have you been in any type of accident? (For Example on the job, automobile, a fall, or injury in a home business, etc.) Yes ____ No ____

IF YES, ANSWER THE REST OF THE QUESTIONS. IF NO, DO NOT ANSWER THE REST OF THE QUESTIONS FOLLOW THE INSTRUCTIONS IN PART C AT THE END OF THIS FORM.

3 - Date of accident _____

4 - What type of accident was this? (Circle one)

accident was at home, school, or on someone else's property	accident was at work	accident involved a vehicle
Answer "HOME or OTHER" questions below.	Answer "WORK" questions below.	Answer "VEHICLE" questions in C below.

HOME: or OTHER

a) If the eccident happened in your home or apartment, do you have a home owner's policy? Yes_____ No_____

If yes, give name and address of insurance company. _____

b) If the accident occurred on someone else's property, where did the accident occur? (for example, at a neighbor's home, a store, a school, etc.) Give name of owner, manager, store, or school, etc._____

Address _____

Give name and address of person's, store's or school's, insurance company, if known _____

WORK:

a) Name of employer, including plant/office/store location._____

b) Did you report the accident to your employer as having happened at work? Yes_____ No_____

c) Has a Worker's Compensation Claim been filed: Yes_____ No_____

VEHICLE:

a) Were you a driver_____, passenger_____, or pedestrian_____?

b) If you were the driver, give your vehicle insurance company name and address. _____

c) If you were a passenger or pedestrian, give driver's name, address, and social security number._____

Give driver's insurance company's name and address

d) Where did the accident occur? Street(s) _____
City _____ County_____

mak30/10a

TQ
Page Two

Part B

1. Have you hired an attorney or has an attorney contacted you? Yes_____ No_____

   If yes, give attorney's name, address, and phone number. _____

   _____

2. Have you been contacted by an insurance company about the accident?
   Yes_____ No_____

   If yes, give policy holder's name. _____ policy #_____

   Insurance company's name and address_____ agent's name, address, and phone # _____

   _____

3. Have you received a settlement or any other money for your injuries? _____
   Yes_____ No_____

   If yes, give amount. _____

   Who issued the money to you? _____

Part C

1. Name of person completing this form. _____

2. Give phone number where you can be reached during the hours 8:00 a.m. to 5:00 p.m. Monday through Friday. _____

3. Other comments or information regarding accident. _____

   _____

Part D

_____ _____
Signature of Person Completing Form Date

THIS FORM MUST BE RETURNED TO MEDICAID. POSTAGE IS PROVIDED.

Fold this form so the Medicaid name and address shows, seal the flap, and put in a mailbox.

kks/#30a11

STATE OF IOWA

TERRY E. BRANSTAD, GOVERNOR

DEPARTMENT OF HUMAN SERVICES

NANCY A. NORMAN, COMMISSIONER

Dear Medicaid Recipient:

We are investigating the possibility that another person may be responsible for payment of medical bills that resulted from your injury. We must have the following information before your medical bills can be processed. If the injured person is a minor, the parent or guardian acting on his/her behalf must complete the questions. Please answer all questions. If the question does not apply, please put NA (not applicable). RETURN THIS FORM WITHIN 10 DAYS.

1. Was your injury the result of an automobile accident_____, a fall_____ a fire_____, an assault or fight_____, or another cause_____.
2. Briefly explain what happened and give date of incident._____
_____.
3. Were any other members of your family injured in this incident? Yes _____ No _____
If so, who?_____
4. If you feel another party is responsible for your injury, please give the name and address_____
5. Do you, or anyone else (absent parent, relative, employer, etc.) have insurance of any kind (other than Title XIX) which will help pay medical expenses? Yes_____ No_____
If yes, who is the policyholder and what is the name and address of the insurance company?_____
_____Policy Number_____
6. Where did the injury occur? (Include address)_____
   (a) Is this your place of residence? Yes_____ No_____
   (b) Who owns the property?_____
   (c) Does the owner have homeowners or property insurance? Yes_____ No_____
   If yes, what is the name and address of the insurance company?_____
   _____ Policy Number_____

(over)

MA-4047-0 (2/85) 470-0398

7. Did your injury occur at work? Yes____ No____. If yes, have you filed a Worker Compensation Claim? Yes____ No____. What is the name of the insurance company?

_____

8. Have you retained an attorney as the result of this injury? Yes____ No____
If yes, give the attorney's name, address, and phone number_____

_____

9. Have you turned in a claim to an insurance company? Yes____ No____ If so, which company? _____ How much have they paid? _____.

10. Were criminal charges filed against anyone in connection with your injury? If so, against whom and in what county?_____.

11. **COMPLETE THIS SECTION IF YOUR INJURIES WERE THE RESULT OF AN AUTOMOBILE ACCIDENT OR INVOLVED ANY OTHER TYPE OF MOTOR VEHICLE (MOTORCYCLE, MOPED, TRACTOR, 3-WHEELER, ETC.)**

(a) Were you a passenger_____, driver _____, pedestrian_____.

(b) If you were a driver or passenger, who owns the automobile in which you were riding? _____

(c) What is the name and address of the owner's insurance company?_____
_____ Policy Number_____

(d) If another automobile was involved in this accident or if you were injured as a pedestrian, list the name and address of the automobile owner._____

_____

(e) What is the name and address of the owner's insurance company?_____

_____

(f) Was a police report filed? Yes____ No____ What city or county?_____

(g) Was anyone determined to be at fault or issued a ticket? Yes____ No____
If so, who? _____.

(h) Do you have automobile insurance on your own vehicle (regardless of its involvement in this accident.)? Yes____ No____
If yes, what is the name and address of the insurance company?_____
_____ Policy Number_____

If you do not have the information that is requested about your injury, please obtain it. Your immediate cooperation will be appreciated. If you have any questions, please call the Third Party Liability Unit at (515) 281-8689. Collect calls are accepted.

Your signature_____ Date_____

Phone number where you can be reached, or a message left:_____

NOTE: FAILURE TO GIVE COMPLETE AND ACCURATE INFORMATION OR FAILURE TO RETURN THIS FORM WITHIN TEN DAYS MAY RESULT IN THE TERMINATION OF YOUR MEDICAID ASSISTANCE.

MA-4047-0 (2/85) 470-0398

NEIL GOLDSCHMIDT
GOVERNOR

Department of Human Resources

ADULT AND FAMILY SERVICES DIVISION

PUBLIC SERVICE BUILDING, SALEM, OREGON 97310

Date _____

Dear _____

We have received a bill from a doctor's office or hospital where you received care on _____ at _____.
The bill is for care you received after an accident or injury.

We need to know the date and cause of the accident or injury. If the doctor's care you received was needed because of an auto accident then fill out the motor vehicle accident form AFS 451; if the doctor's care you received was because of a non-auto accident then fill out the personal injury form AFS 451NV.

If you know of any insurance or other help which will pay for these doctor services, please send the name with the form.

Examples of other help are: AUTO INSURANCE (yours or another person's) HOMEOWNER'S OR RENTER'S INSURANCE, WORKERS COMPENSATION (SAIF), HEALTH INSURANCE, or SCHOOL INSURANCE.

If you have questions please call _____ at 373-7800 Ext. 359 for long distance calls at no cost to you use the number, 1-800-527-5772.

Your call will be returned between the hours of 8:00 a.m. and 3:30 p.m.

All personal injuries are required to be reported under Oregon law. Failure to report or complete this form will result in termination of your grant.

Send the completed form to AFS in the envelope that is with this letter, The form must be filled out and mailed to AFS Health Insurance Group by _____.

Third Party Recovery Unit
Recovery Service Section

AN EQUAL OPPORTUNITY EMPLOYER

STATE OF OREGON
DEPARTMENT OF HUMAN RESOURCES
ADULT & FAMILY SERVICES DIVISION

DISTRIBUTION:
ORIGINAL: PERSONAL INJ. LIENS
COPY: CASE RECORD

VEHICLE RELATED PERSONAL INJURY

☐ NEW
☐ CHANGE

PROGRAM	BRANCH #	CASE NUMBER
CASE NAME		WKR ID
INJURED PERSON'S PRIME #		WORKER PHONE NUMBER

1. NAME AND ADDRESS OF INJURED PERSON:

2. DATE OF INJURY/ACCIDENT

3. WERE YOU EMPLOYED AT TIME OF ACCIDENT? ☐ YES ☐ NO

4. DID YOU APPLY FOR ASSISTANCE DUE TO INJURIES FROM THIS ACCIDENT? ☐ YES ☐ NO

4A DATE ASSISTANCE STARTED

5. LOCATION/ADDRESS WHERE INJURY/ACCIDENT OCCURRED (INCLUDE CITY AND STATE)

6. DID THE POLICE INVESTIGATE THE ACCIDENT? ☐ YES ☐ NO

6A IF YES, BY WHOM? ☐ CITY POLICE ☐ STATE POLICE ☐ COUNTY SHERIFF

7. WAS A CITATION ISSUED? ☐ YES ☐ NO

7A IF YES, TO WHOM?

8. HAVE YOU APPLIED FOR ANY BENEFITS? ☐ YES: TYPE _____ ☐ NO

8A WAGE-LOSS BENEFITS: APPLIED FOR? ☐ YES ☐ NO
RECEIVED? ☐ YES: $ _____ ☐ NO

8B DO YOU HAVE AUTOMOBILE MEDICAL BENEFITS OR "PIP" BENEFITS? ☐ YES ☐ NO

9. HAVE YOU FILED A CLAIM FOR DAMAGES? ☐ YES ☐ NO

9A HAS THE CLAIM BEEN SETTLED OR COMPROMISED? ☐ YES: $ _____ ☐ NO
DATE: _____

10. WERE YOUR MEDICAL EXPENSES COVERED? ☐ YES: INS. CO. _____ POLICY # _____ ☐ NO

10A ARE YOUR MEDICAL EXPENSES STILL COVERED? ☐ YES ☐ NO

11. YOUR ATTORNEY'S NAME

11A ATTORNEY'S ADDRESS/CITY/STATE

11B ATTORNEY'S PHONE

	VEHICLE # 1: INJURED PERSON'S VEHICLE	VEHICLE # 2: OTHER VEHICLE
12. DRIVER'S: NAME		
ADDRESS	PHONE	PHONE
INSURANCE COMPANY	POLICY #	POLICY #
INSURANCE CO.'S ADDRESS		
ADJUSTER'S NAME	PHONE	PHONE
13. OWNER'S: NAME		
ADDRESS		
INSURANCE COMPANY	POLICY #	POLICY #
INSURANCE CO.'S ADDRESS		
ADJUSTER'S NAME	PHONE	PHONE

14. INJURED PERSON'S INSURANCE CO.

14A POLICY #

14B ADJUSTER'S NAME

14C ADJUSTER'S PHONE

STATE OFFICE USE ONLY	EXPENSE AVOID. STATUS		DATE 451 RECEIVED	INJ/ACC		SOURCE	COVERAGE	LIEN FILE	
	CODE	DATE		CODE	DATE			DATE	STATUS

AFS 451 (REV 5/82)

15. SHOW CAR NUMBER 1 AS INJURED PERSON'S VEHICLE
SHOW CAR NUMBER 2 AS OTHER VEHICLE

VEHICLE # 1 → 1

VEHICLE # 2 → 2

INDICATE NORTH BY ARROW

STREET

STREET

16. DESCRIBE THE ACCIDENT

17. LIST INJURIES RECEIVED

I declare that the information I have given on this form is correct and complete to the best of my knowledge. I understand that to knowingly give false information or to withhold information may result in a fine, imprisonment, or both. If I am unable to provide verification for any of the information on this form, I will authorize the Adult and Family Services Division to contact persons or agencies to obtain verification.

CLIENT'S SIGNATURE	DATE	CLIENT'S PHONE #

PURPOSE OF FORM:
1. To determine if alternative resources are available to meet medical and/or maintenance expenses incurred due to the accident/injury.
2. To file a lien on any claim for damages resulting from the accident/injury.

COMPLETION OF FORM: COMPLETE ONE FORM FOR EACH INJURED APPLICANT/RECIPIENT

Most questions are self-explanatory. If you need help, contact your assistance worker. If a question is not applicable, enter N/A.

SHADED AREAS: To be completed by Adult and Family Services staff.

All personal injuries are required to be reported under Oregon law. Failure to report or complete this form will result in termination of your grant.

STATE OF OREGON
DEPARTMENT OF HUMAN RESOURCES
ADULT & FAMILY SERVICES DIVISION

DISTRIBUTION:
ORIGINAL: PERSONAL INJ. LIENS
COPY: CASE RECORD

☐ NEW	PROGRAM	BRANCH #	CASE NUMBER	
☐ CHANGE	CASE NAME			WKR ID
	INJUREO PERSON'S PRIME #		WORKER PHONE #	

NON-VEHICLE RELATED PERSONAL INJURY

1. NAME AND ADDRESS OF INJUREO PERSON:

2. DATE DF INJURY/ACCIDENT

3. DID YOU APPLY FDR ASSISTANCE DUE TO INJURIES FROM THIS ACCIDENT? ☐ YES ☐ NO

4. DATE ASSISTANCE STARTEO

5. WERE YOU EMPLDYEO AT TIME DF ACCIDENT? ☐ YES ☐ ND

6. LOCATION/ADDRESS WHERE INJURY/ACCIDENT OCCURREO (INCLUDE CITY AND STATE):

7. STATE WHAT HAPPENEO, HOW, BY WHOM CAUSEO, AND INJURIES RECEIVEO:

8. IF INJURY OR ACCIDENT IS THROUGH JOB

NAME OF EMPLOYER

ADDRESS

CITY STATE ZIP

CLAIM #

9. IF INJURY OR ACCIDENT IS NOT THROUGH JDB

NAME DF PERSON/DRGANIZATION CAUSING INJURY

ADDRESS

CITY STATE ZIP

ID.

ATTORNEY HANDLING YOUR CASE

NAME

ADDRESS

CITY STATE ZIP

11. HAVE YOU APPLIEO FOR BENEFITS?
☐ YES: TYPE _____
☐ NO

12. HAVE YOU FILED A CLAIM FOR DAMAGES?
☐ YES ☐ ND

13. WAGE-LOSS BENEFITS:
APPLIED FOR? ☐ YES ☐ NO
RECEIVED? ☐ YES: $_____ ☐ ND

14. HAS THE CLAIM BEEN SETTLEO OR COMPROMISED?
☐ YES: $_____ ☐ NO
OATE: _____

15. WERE YOUR MEDICAL EXPENSES COVEREDT
☐ YES: INS.CO. _____
POLICY # _____
☐ ND

16. ARE YOUR MEDICAL EXPENSES STILL COVEREDT
☐ YES ☐ NO

17. INSURANCE COMPANY HANDLING CLAIM

NAME

ADDRESS

CITY STATE ZIP

17A. POLICY NUMBER

17B. CLAIM NUMBER

17C. ADJUSTER'S NAME

17D. ARE YOU THE POLICY HOLDER?
☐ YES ☐ NO

I declare that the information I have given on this form is correct and complete to the best of my knowledge. I understand that to knowingly give false information or to withhold information may result in a fine, imprisonment, or both. If I am unable to provide verification for any of the information on this form, I will authorize the Adult and Family Services Division to contact persons or agencies to obtain verification.

CLIENT'S SIGNATURE

DATE

CLIENT'S PHONE #

STATE OFFICE USE ONLY	EXPENSE AVOID. STATUS		DATE 4S1NV RECEIVED	INJ/ACC		SOURCE	COVERAGE	LIEN FILE	
	CODE	DATE		CODE	DATE			DATE	STATUS

INSTRUCTIONS FOR AFS 451NV

PURPOSE OF FORM: 1. To determine if alternative resources are available to meet medical and/or maintenance expenses incurred due to the accident/injury.

2. To file a lien on any claim for damages that results from the accident/injury.

COMPLETION OF FORM: COMPLETE ONE FORM FOR EACH INJURED APPLICANT/RECIPIENT

Most questions are self-explanatory. If a question is not applicable, enter N/A. If you need help to complete this form, contact your assistance worker.

SHADED AREAS: To be completed by Adult and Family Services staff.

All personal injuries are required to be reported under Oregon Law. Failure to report or complete this form will result in termination of your grant.

MEDICAID
MEDICAL SERVICES
QUESTIONNAIRE

STATE OF TENNESSEE
Dept. of Health & Environment
PO Box 490
Nashville, TN 37202-0490

STATE LAW REQUIRES RECIPIENT TO PROVIDE INSURANCE INFORMATION

Dear Medicaid Recipient or Representative:

Our records indicate that you have received medical services. We need to have you answer the questions on this form so we can tell if an insurance company or a third party may be responsible for payment. Please answer all questions that apply to you. If a question does not apply, indicate "NA" (not applicable). If you do not have the information, please obtain it.

RECIPIENT DATA

Medicaid ID:

Date(s) of Service:

If you were injured, or in an accident, complete questions 1-8.

1. Date and nature of injury or accident: _____

2. Were medical services for an injury which was: _____ Work Related, _____ Auto Related, or _____ Other?

3. If "work related", give name and address of employer:

If "other", explain:

5a. If "auto", give name of driver(s): 1) _____
2) _____

b. Name of insured: 1) _____, 2) _____

c. Name of insurance company(s): 1) _____
2) _____

Address: _____

d. Claim or policy number(s): 1) _____, 2) _____

e. Claim Adjuster: _____ Phone # _____

6a. Have you hired an attorney? _____ yes _____ no

b. If yes, name, address and phone number:

7a. Have you received a settlement? ___ yes ___ no

b. If yes, amount: $ _____

8. Name and address of insurance company or individual making payment to you:

9. Do you have other medical or health insurance? _____ yes _____ no

If yes, Name: _____

Policy and Group Number: _____

you have any questions, you may call 1-800-342-3145 (in Nashville, call 741-0192) and ask to speak with a TPL .presentative. Please return this form within fourteen (14) days. Your cooperation will be appreciated.

Signature: _____ Phone No.: (_____) _____

TDHE-620 (9-89)

SECOND FOLD

NO POSTAGE NECESSARY IF MAILED IN THE UNITED STATES

BUSINESS REPLY MAIL

FIRST CLASS PERMIT NO. 6275 NASHVILLE, TENN.

POSTAGE WILL BE PAID BY ADDRESSEE

STATE OF TENNESSEE
Department of Health & Environment
TPL Section - AQ
PO Box 490
Nashville, TN 37202-9905

FIRST FOLD

MOISTEN, SEAL, AND DROP IN MAILBOX. NO POSTAGE IS NECESSARY.

TEXAS DEPARTMENT OF HUMAN SERVICES

THIRD PARTY RESOURCES QUESTIONNAIRE

(Vea Español al Otro Lado)

Date

State Office Codes		Run Date
BJN	Mail Code	Client No.
Diagnosis		

Medicaid has paid a bill from for

This bill was for services performed on

BECAUSE MEDICAID HAS PAID THIS BILL FOR YOU, YOU MUST ANSWER THIS QUESTIONNAIRE. FAILURE TO COOPERATE COULD CAUSE YOU TO LOSE YOUR MEDICAID BENEFITS.

1. Give a brief description of the accident (date, place, how it occured, anybody's fault):

_____

_____

_____

2. Do you have an attorney representing you in this matter? ..... ☐ YES ☐ NO

If "Yes", give attorney's name:	Address	Telephone No.

3. So far as you know, is an insurance company involved? ..... ☐ YES ☐ NO

If "Yes", give name of the insurance rep.	Address	Telephone No.
Name of Insurance Company	Name of Policy Holder	Policy No.

4. Has a settlement been made? ..... ☐ YES ☐ NO

If "YES," who received money? _____

PLEASE SIGN BELOW AND RETURN IMMEDIATELY IN THE ENCLOSED PREPAID ENVELOPE. If you have any questions, call toll free 1-800-252-9165 (Austin residents should call 343-4970.)

Telephone No.

_____ _____

SECTION V

STATE TPL FORMS

5. Medical Assistance Termination Notice

Iowa Department of Human Services

Interoffice Memo

Date:

To/Office: Department of Human Services County Office:

Attention: Worker #

From/Office: TPL, Medical Services, 5th Floor Hoover Bldg.

Subject: Medical Assistance Termination Notice

Recipient Name_____Case No._____

This is to inform you that this recipient(s) has:

_____ Received payment from a medical resource, such as insurance or lawsuit settlement, and has failed to reimburse the Department for costs of medical care.

_____ Failed to provide information to the Department as requested by the Bureau of Medical Services.

_____ Failed to cooperate, without good cause, in filing or processing a claim or an application for a reasonably available medical resource.

This has adversely affected the Department's right of recovery. The medical assistance eligibility of the adult members of the household is being terminated, (VIII-B).

Comments: _____

_____

Medical Assistance eligibility for this recipient should be cancelled effective

_____. None of the children's medical eligibility is affected, nor does this action affect the amount of the cash grant. Please generate a Notice of Decision to inform the recipient of this action.

TD CODING PROCEDURE - SECTION VII

FIELD	CODE	DESCRIPTION
171	G	Change with a timely notice.
205	N	Cancelled
206	960	_____ is not eligible for Medical Assistance because of failure to cooperate with the Third Party Liability Unit.
209	7	Not eligible for medical assistance; may be eligible for grant only.

470-0409 (Rev. 10/86) White -- Client file Yellow -- TPL file

SECTION V

STATE TPL FORMS

6. IV-D/TPL INQUIRY

THIRD PARTY LIABILITY SECTION
POST OFFICE BOX 19120
SPRINGFIELD, ILLINOIS 62794-9120

DATE:
CASE NAME:
IV-D NUMBER:
S.S. NUMBER:
BIRTH DATE:
DEPENDENT(S):

You have been ordered to provide health insurance for your dependent(s).

If there is not a health insurance plan available through your employer, you must provide the health insurance through any health insurance plan available on a group basis or obtain an individual health insurance policy.

To comply with the support order, you must provide written proof to the Illinois Department of Public Aid that the required insurance has been obtained, or that application for insurability has been made, within 30 days of receiving notice of the support order. If you were present at the court hearing your 30 days begin from the date you were there and received your order.

If you fail to provide or maintain health insurance pursuant to the order for support, you are liable for:

- the dollar amount of the premiums which were not paid,
- all medical expenses incurred by the minor child(ren) which could have been paid or reimbursed by the health insurance which you were ordered to provide or maintain.

Further enforcement action in court may occur for your failure to pay the premiums for ordered health insurance.

Complete this form within 30 days to verify that health insurance coverage is being provided. Failure to complete and return this form could result in legal action being taken against you. If you are unable to provide the necessary information requested on the back of this notice, contact your insurance agent for assistance. All questions must be answered.

RECEIVED
DEC 14 1989
THIRD PARTY
LIABILITY
SECTION

DPA 2593 (R- -) (over) IL478-1266

HEALTH/HOSPITALIZATION INSURANCE

CASE NAME: _____ IV-D CASE #: _____

YOUR NAME: _____

YOUR BIRTHDATE: _____

YOUR SSN: _____

Is your dependent(s) covered by group insurance?

_____ YES If "YES" complete PART A and PART C

_____ NO If "NO" complete PART B and PART C

PART A

1. NAME OF INSURANCE COMPANY: _____

2. GROUP INSURANCE NUMBER: _____ ID NUMBER: _____

3. DATE THAT YOUR COVERAGE BEGAN: _____ DATE ENDED: _____

4. NAME OF YOUR GROUP: _____
(If Union, complete name and local number).

5. COMPLETE ADDRESS OF GROUP: _____
(street)

_____ _____ _____
(city) (state) (zip code)

6. Amount of the premium you must pay: $_____ per _____

PART B

Individual health/hospital insurance that you purchased to cover your dependent(s).

1. NAME OF INSURANCE COMPANY: _____

2. YOUR INSURANCE POLICY OR CERTIFICATE NUMBER: _____

3. COMPLETE ADDRESS WHERE CLAIMS ARE MAILED: _____
(street)

_____
(city) (state) (zip code)

4. Amount of the premium you must pay: $_____ per _____.

PART C

Enter the complete name of each covered dependent whom you are responsible for as stated in the order and the date insurance coverage began.

NAME	DATE (M-D-Y)	NAME	DATE (M-D-Y)

YOUR SIGNATURE DATE

SECTION V

STATE TPL FORMS

7. Health Insurance Premium

State of California—Health and Welfare Agency

Department of Health Services

HEALTH INSURANCE PREMIUM PAYMENT REFERRAL

1. Name of Applicant/Beneficiary

2. Medi-Cal Identification Number

Applicant/Beneficiary Address

3. Social Security Number

City | State | ZIP Code

4. Telephone Number (Include area code)

5. Policy Status (Check appropriate box)

a. ☐ Policy will lapse on _____ b. ☐ Policy lapsed on _____ c. ☐ Medical coverage available, but not applied for

6. Type of Coverage Your Insurance Provides or Pays for (Check all that apply):

- ☐ Hospital stays
- ☐ Hospital outpatient (i.e., lab work or physical therapy)
- ☐ Doctor visits
- ☐ Prescription drugs
- ☐ Dental care
- ☐ Vision care
- ☐ Medicare supplement
- ☐ Only specific illness (i.e., cancer)

Type of illness _____

7. Policy Number:

8. Premium Amount

$_____ ☐ Per month ☐ Per year

9. How are Premiums Paid? (Check appropriate box)

a. ☐ Paid by insured to insurance carrier b. ☐ Employer Paid c. ☐ Payroll deducted

10. Name of Insured Policyholder

Social Security number

Address of Insured Policyholder

Telephone Number

11. Name(s) of Other Medi-Cal Eligible Family Member(s) Covered Under the Health Insurance Policy

12. Does Any Covered Beneficiary Have an Acute, Chronic, Pre-existing Illness that Requires Him/Her to see a Physician?

☐ Yes ☐ No If yes, please specify the individual's name and the illness: _____

13. Premium Billing Location (Where Premiums are Mailed and Processed):

Name of Insurance Company, Employer or Union

Address of Insurance Company, Employer or Union

14. Name of Employer:

Address of Employer:

Telephone Number of Employer

15. List Additional Health Insurance Coverage, if Any (Complete a Separate Health Insurance Premium Payment Referral)

IMPORTANT: As a condition of eligibility, all Medi-Cal beneficiaries shall assign rights to medical insurance, support, or other third-party payments to the Medi-Cal program and shall cooperate with the Department of Health Services in obtaining medical support or payments. The assignment of rights to benefits is effective only for services paid for by the Medi-Cal program. Assignment of medical rights allows the Department of Health Services to recover funds from health insurance companies or funds when the Medi-Cal program pays for medical services which should have been billed to other health insurance coverage. Please note that in order to comply with the Federal Privacy Act (42USC, Section 552a) your Social Security number and any information your provide may be used to contact insurance companies, employers, providers of health care services, and county agencies to determine the extent of available health insurance. Under Welfare and Institutions Code, Section 14100.2, any submitted information is considered confidential and disclosed only as necessary for Medi-Cal program administration purposes.

AUTHORIZATION: "I hereby authorize the Department of Health Services to obtain, if needed, any information regarding my private health insurance coverage, including payments and/or benefits for medical care made in my behalf, which may be used in determining if the Department will pay health insurance premiums for continued coverage."

Signature of Applicant/Beneficiary (or Authorized by):

Date:

DHS 6172 (5/89)

INSTRUCTIONS FOR HEALTH INSURANCE PREMIUM PAYMENT REFERRAL
FORM DHS 6172

A. Under certain circumstances, the Department of Health Services (DHS) is authorized to pay a Medi-Cal recipient's health insur premiums (Welfare and Institutions Code, Section 14124.91). If health insurance is available to you through your employer, l union, trust fund, or other source but you have not applied for it, or if your health insurance has or is about to lapse, please com this form. Return the completed form to your eligibility worker or mail it to DHS in tha postage paid envelope. If you have questions about completing this form or require Spanish translation, call toll free 1-800-952-5294 California only (7:30 a.m.–5:00 p It is important that you attach a copy of your health insurance policy to this form.

B. The following instructions are to be used in completing the Health Insurance Premium Payment Referral. *Please print the informa*

1. List your full name, street address, city, state, and ZIP code.
2. Enter your current 14-digit Medi-Cal identification (ID) number. Ask your eligibility worker for assistance, if necessary.
3. Enter your 9-digit Social Security number.
4. List your complete daytime telephone number. If you do not have a telephone please put a message number in the telep number box.
5. Indicate your health insurance policy status. Check box "a." or "b." to identify whether your insurance coverage will lap has lapsed. Enter the correct date on the line provided. Check box "c." if you do not currently have medical coverage bu available to you or other family members. (Note: Children may be eligible for health insurance through the absent pa employer.)
6. Indicate by a check in the appropriate box(es) the medical services that are covered by your health insurance policy.
7. Enter your health insurance policy number. This number is sometimes called the subscriber, certificate, account, emp group, or local number.
8. Enter the amount that is paid for your health insurance premiums and chack the box if they are paid per month or per Include the amount paid by the insured as well as any premium paid by the employer.
9. How are your premiums paid? Check the appropriate box to identify whether the premiums are: a. Paid by the insured di to the insurance carrier, b. Paid by your employer, or c. deducted from your paychack.
10. List the full name, Social Security number, address, and telephone number of the insured/policyholder. This is the name person to whom the policy was issued.
11. List the name(s) of the family member(s) covered under the health insurance policy who are currently Medi-Cal eligible.
12. Check "Yes" or "No" if any person listed in item one (1) or nine (9) has an acute, chronic or pre-existing medical illn "Yes," list the individual's name and medical illness on the line provided. This information is important to mak determination whether the Department will pay the premium.
13. Enter the complete Premium Billing Location for paying your health insurance premiums. Include name and address health insurance company, employer, or union.
14. Enter the complete name, address, and telephone number of the employer through which the policy was purchased.
15. List any additional insurance coverage. If there is multiple insurance coverage, identify tha name and address of tha insurance company(ies) and complete a separate Health Insurance Premium Payment Referral.

Signature Section: Please sign the form and enter the date when you completed this form.

DHS-2841 (
PZ-02841-01

Health Insurance Premium — Cost Effectiveness Review

Mail to: Department of Human Services
Benefit Recovery Section
444 Lafayette Road
St. Paul, MN 55155-3850

County Use

1 Date:

A. ☐ Applicant ☐ Recipient

B. ☐ Initial Review ☐ Re-Review

Check at least 1 box in each A, B, and C

C. ☐ MA ☐ GAMC ☐ AFDC ☐ Ext. Medical ☐ TEFRA Option ☐ QMB Status ☐ Other (Specify) _____

Recipient Info.

2 Recipient Case Name: | Age:

MA-ID (16 digit number):

Policy up to date? ☐ Yes ☐ No | Policy holder (name/relationship)

Other covered persons name, date of birth or age:
Public Assistance | Non Public Assistance

Insurance Info

3 Insurance Company Name: | Employer Name: | Policy No.

Address: Phone No:

City: State: Zip Code:

Premium Amount: | Date Due: | Is the amount: ☐ weekly ☐ bi-weekly ☐ monthly ☐ quarterly ☐ yearly

Type of Policy:
☐ Individual ☐ HMO
☐ Employer/Group ☐ Medicare: F
☐ Medicare Supplement ☐ Other
☐ HMO Medicare Supplement

Medical Conditions

4 Have you or any family member(s) been treated by a doctor in the past year? ☐ Yes ☐ No

Describe the illness and kind of medical care:

How often have you or a family member in the assistance unit had the following medical care (in past year):

Hospitalization	Doctor's Visits	Prescriptions	
_____ times in past 2 years (inpt.)	_____ times per month	_____ number filled per month	_____ number filled per year
_____ times in past 2 years (outpt.)	_____ times per year	_____ cost per month	_____ cost per year

Collection of Information

I authorize any person, medical provider, insurance company, or other organization or agency to provide to the Department of Human Services upon request any information about my or my dependents' health insurance, medical treatment and employment.

Copies of this form are legal. The information will be used to decide payment of your health insurance premiums. The information will not be used for any other purpose.

Signature _____ Date _____

County Use

5 Worker Name: | Phone Number:

Agency Name:

Agency Address:

City: State: Zip Code:

Attach copy of complete insurance policy

Attach copies of paid claims or payment reports if available from the last 12 months

5A Check all conditions that apply:
☐ Spend down: ☐ Monthly ☐ 6-Month —
☐ Parental or spousal contribution
☐ Medicaid/GAMC pre-paid health plan enrollee
☐ Medicaid waiver eligibility: _____ (waiver type)
☐ Client has Medicare: ☐ Part A ☐ Part B
☐ Short-term eligibility anticipated: ☐ Medical Leave ☐ Lay Off ☐ Other
☐ Absent parent court ordered to maintain coverage
☐ Client living in a nursing home. Is nursing home care currently covered by insurance? ☐ Yes ☐ No
☐ None of the above

State Use

6 Decision for Payment of Premiums

☐ Approved. Send Health Insurance Information Form (DHS-1922) if not previously sent.

☐ Denied. We are unable to pay the health insurance premiums because they have not been found cost effective. If they wish to continue the insurance coverage, they are responsible for the premium payments. If you have additional information about their medical condition not included Section 4 above, please contact Benefit Recovery Section.

☐ More information is needed. Please send _____

Code the following Coverage Types in Section 3 of the DHS-1922: _____

Signed _____ Date _____

SUBMIT ALL COPIES TO DHS

DHS-BENEFIT RECOVERY

SECTION V

STATE TPL FORMS

8. Notice To Recipients

DHS-2810 (10-88)
Printed by Department
of Human Services

THIRD PARTY LIABILITY NOTICE TO RECIPIENTS

Read the notice carefully before you call your worker with questions. the notice has important facts that tell you:

- You must use health insurance, health maintenance organization (HMO), and accident benefits before using Medical Assistance (MA) or General Assistance Medical Care (GAMC).
- You must cooperate to get MA or GAMC.
- If you file a lawsuit to get money because of an injury, the Department of Human Services (DHS) may file a claim in your suit.

INFORMATION YOU SHOULD KNOW

- You must report to your financial worker:
  - health or accident insurance you have
  - changes in your insurance
  - lawsuits you file because you are injured
  - workers' compensation claims you file
- You must sign over your rights to payment of medical care from any third party, such as an insurance plan, absent parent, etc.
- You must help us get grant money and medical payments from any liable person or company.
- We may be able to pay your premium if you pay for health insurance now or can get it through your work. We must review it to see if it will save money. Contact your worker if you need to know more about this.

REPAYMENT OF ASSISTANCE OUT OF INJURY SETTLEMENTS

If you file a claim to get money because of an injury, DHS may file a claim in your lawsuit. We may file a claim for the cost of medical care or grant money paid to you or your family because of the injury. Grant money means General Assistance (GA), Aid to Families with Dependent Children (AFDC), and other cash payments.

WHAT WILL HAPPEN IF YOU DO NOT COOPERATE?

You must cooperate to get MA or GAMC. If you do not cooperate, you may lose your MA or GAMC.

WHAT ARE HEALTH INSURANCE AND HMO REQUIREMENTS?

Medical providers must bill insurance you have before they bill MA/GAMC. Medical providers means doctors, hospitals, drug stores, etc. People with private HMO or insurance coverage must use it before MA/GAMC. You may be covered through someone's work insurance plan or former work plan, or a Medicare Supplement plan. You or your child(ren) may be covered by an absent parent.

WHAT HAPPENS IF YOU HAVE PRIVATE HMO OR INSURANCE COVERAGE?

For care that your HMO or insurance plan pays for, you must follow the rules of the plan to get the care. Your plan may have some or all of these rules:

- You may need to go to certain medical providers.
- You may need to get permission from the HMO or insurance plan first.
- You may need a referral for some care or some providers.

Get a copy of your HMO or insurance plan to know the rules you must follow.

MA will not pay for care which could have been paid by an HMO or insurance plan. MA will pay for care not covered by tha plan (if it is covered by MA) and for co-payment fees up to the MA allowable. If you are paid by the insurance company, you must pay that money to your medical provider. You are not allowed to keep money paid to you for medical care.

You may have to get a denial from your HMO or insurance plan or have a copy of your policy. This will show the provider that a service is not covered by the plan.

WE WILL GET INFORMATION ABOUT YOU

By Federal Law, we must check for health insurance or other third party benefits you may be able to get. We must check data about you with other agencies or third party payers. We will use your Social Security Number to check data with:

—Minnesota Department of Labor and Industry - records of workers' compensation benefits

—Minnesota Department of Motor Vehicle - licensing, registration and accident information

—Minnesota Department of Jobs & Training - records of wages and warnings

—Private health insurance plans - records of insured persons

—Private HMO plans - records of insured persons

—United States Social Security Administration (SSA) - records of self-employment earnings, retirement income, survivors benefits, disability payments, Social Security (RSDI), and Supplemental Security Income (SSI)

This form has important welfare information. If you do not understand it, get help now.

ឯកសារបានផ្តល់ជូនមានព័ត៌មានសំខាន់ៗ ប្រសិនបើលោកអ្នកមិនយល់ សូមស្វែងរកជំនួយភ្លាមៗ

ᨾᩣᨶᩁᩣᨿᨡᩣᨶᨾᩣᨶᨻᩣᨶᩈᩣᨾᩈᩣᨾ

SECTION VI

FEDERAL AND STATE REFERENCE DATA

Part A

Federal Reference Data

HEALTH CARE FINANCING ADMINISTRATION

The Health Care Financing Administration (HCFA) was created by order of the Secretary of Health, Education and Welfare on March 9, 1977, to bring together under one administration the management of the Medicare and Medicaid programs.

HCFA's mission is:

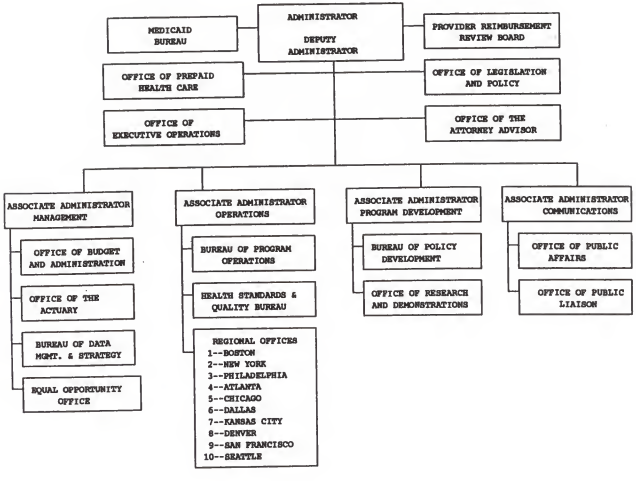
- To ensure the effective administration of its programs in order to promote the timely delivery of appropriate, quality health care to its beneficiaries;
- To make certain that beneficiaries are aware of the services for which they are eligible, that those services are accessible to them and are provided in the most effective manner; and
- To ensure that its policies and actions promote efficiency and quality within the total health delivery system which serves all Americans.

The focal point for Medicaid TPL operating instructions and policy guidance to Medicaid State agencies and regional offices is the TPL Branch, Division of Payment Systems, Office of Medicaid Management, Medicaid Bureau. The TPL effort is one of HCFA's major Medicaid initiatives.

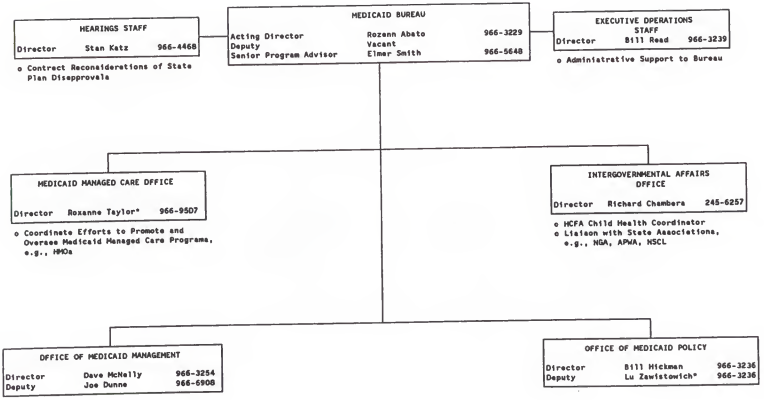
By cost avoiding Medicaid billings to legally liable third parties, and by increasing TPL collections from them, States and the Federal government have a great opportunity to achieve significant savings for the program which is intended to be the "payer of last resort." The placement of the TPL component within the organization of HCFA is intended to facilitate these activities, and to enhance the TPL effort within the agency, throughout the ten HCFA regions, and in the States.

Following are HCFA organizational charts and a brief description of the duties and responsibilities of those components with Medicaid-related functions.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION



HEALTH CARE FINANCING ADMINISTRATION
MEDICAID BUREAU



*Acting

HEALTH CARE FINAN. .G ADMINISTRATION
MEDICAID BUREAU
OFFICE OF MEDICAID POLICY

OFFICE OF MEDICAID POLICY

Director	Bill Hickman	966-3254
Deputy	Lu Zawistowich*	966-3255

DIVISION OF PAYMENT & COVERAGE POLICY

Director	Bill Hickman*	966-3236

MEDICAID PAYMENT POLICY BRANCH

Chief	Bernie Truffer	966-4576

- Development and Interpretation of Medicaid Institutional and Cost-Related Reimbursement Policy

HOME & COMMUNITY BASED WAIVERS BRANCH

Chief	Bob Wardwell	966-5659

- Processing of Home & Community-Based Waivers
- Policy on Targeted Case Management, Abortions, Sterilizations

MEDICAID SPECIAL POLICY ISSUES BRANCH

Chief	Vacant

- Policy on Other Medicaid-only Coverage and Reimbursement Issues

DIVISION OF MEDICAID ELIGIBILITY POLICY

Director	Marty Svolos	966-4451

MEDICAID ELIGIBILITY ASSESSMENT BRANCH

Chief	Mike Fiore	966-4460

- Development and Interpretation of Medicaid Eligibility Policy, TPL Policy
- Freedom of Choice Waivers

MEDICAID ELIGIBILITY POLICY BRANCH

Chief	Dick Coyne	966-4458

- Development and Interpretation of Medicaid Eligibility Policy

*Acting

HEALTH CARE FINANCING ADMINISTRATION
MEDICAID BUREAU
OFFICE OF MEDICAID MANAGEMENT

OFFICE OF MEDICAID MANAGEMENT

Director	Dave McNally	966-3254
Deputy	Joe Dunne	966-3255

DIVISION OF FINANCIAL MANAGEMENT

Director	Bill Lesowski	966-2003
Deputy	Don Allen	966-3271

FINANCIAL POLICY BRANCH

Chief	Bill McQuay	966-3257

- Federal Matching Policy
- Medicaid Disallowances
- Financial Management Reviews
- Spectrum Reviews

BUDGET AND GRANTS BRANCH

Chief	Miles McDermott	966-2005

- Medicaid Budget/Forms HCFA-25
- Medicaid Grant Awards/Forms HCFA-64
- Focal Point for Medicaid Budget and Expenditure Data
- Focal Point for Automated Medicaid Budget and Expenditure System

PROGRAM INITIATIVES BRANCH

Chief	Bill Hiscock	966-3275

- Home and Community-Based Services Oversight - Form HCFA-372
- Freedom of Choice Waivers Oversight
- Early and Periodic Screening Diagnosis and Treatment
- Maternal and Infant Health Initiative
- AIDS Initiative
- Other Special Initiatives

DIVISION OF PROGRAM PERFORMANCE

Director	Randy Graydon	966-3294
Deputy	Elliot Heide	966-6918

ELIGIBILITY ASSESSMENT BRANCH

Chief	Kathy Rema	966-5929

- Medicaid Eligibility Quality Control Operations and Policy
- Operational Eligibility Data Coordination with SSA
- Negative Case Action Quality Control
- Medicaid Eligibility Corrective Action

MEDICAID OPERATIONS BRANCH

Chief	Helaine Jeffers	966-5920

- Income Eligibility Verification Systems
- Medicaid Compliance
- State Plan Process Oversight
- Systematic Alien Verification for Entitlements
- Focal Point for Medicaid Operational Issues

STATISTICAL ANALYSIS BRANCH

Chief	Roger Buchanan	966-5903

- Program Development Technical Support to Medicaid
- Data Base Systems for Medicaid Eligibility Quality Control
- Integrated Quality Control

DIVISION OF PAYMENT SYSTEMS

Director	Rick Friedman	966-3292
Deputy	Dan Boyle	966-5913

THIRD PARTY LIABILITY BRANCH

Chief	Vacant	966-3392

- Third Party Liability
- First Party Liability (e.g., Liens, Estate Recoveries)
- Qualified Medicare Beneficiaries
- Qualified Disabled Working Individuals
- Utilization Management
- Title IV-D Coordination Support

SYSTEMS REQUIREMENTS BRANCH

Chief	Jim Dunnigan	966-3203

- Medicaid ADP Procurement Approvals
- Certification of Replacement MMISs & IESs
- State Systems Liaison
- Reports: Fiscal Agents and Integrated Eligibility Systems

SYSTEMS PERFORMANCE BRANCH

Actg Chief	Larry Reed	96[illegible]-0830

- Systems Performance Review of Medicaid Management Information Systems
- Electronic Verification
- Systems Support for Medicaid Capitation
- MMIS System Policies

PROGRAM QUALITY EVALUATION BRANCH

Chief	Al Beechley	966-3325

- ADP Support to Bureau
- MB Lead on HCFA's Systems Management Effort (PRISM)
- System Security
- Coordination of New PC Hardware Distribution
- State-of-the-Art PC Maintenance Through Purchase/Distribution of PC Software Packages

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
ASSOCIATE ADMINISTRATOR FOR OPERATIONS
OFFICE OF THE REGIONAL ADMINISTRATOR

OFFICE OF THE REGIONAL ADMINISTRATOR (FPD*)

DIVISION OF HEALTH STANDARDS AND QUALITY (FPC*A)

- Assures efficient/effective provision of health care services
- Monitors State survey agency certification activities for Medicare and Medicaid
- Manages peer review activities to include PRO contract negotiation/oversight
- Manages State survey agency budget
- Approves/denies provider certification actions under Medicare

DIVISION OF MEDICAID (FPD*E)

- Monitors/evaluates States agency compliance with the State plan
- Review/approve Medicaid State plans, amendments, and waivers
- Review/approve institutional payment plans, cost allocation plans, contract expenditures, and quarterly estimates of expenditures
- Conducts systematic QC programs (claims payment, eligibility)
- Defers payment on questionable claims and suspends FFP in State payments to ineligible institutions
- Provides technical assistance on selected policy and operational issues; e.g., TPL

DIVISION OF MEDICARE (FPD*F)

- Negotiates/monitors contracts and budgets with intermediaries and carriers
- Interprets Medicare policy, procedures, regulations, and law for contractors, beneficiaries, providers, and associations
- Approves final cost settlements with contractors
- Conducts contractor oversight/ evaluation activities to ensure adherence to Medicare rules and payment principles
- Conducts education programs for beneficiaries and providers to to increase awareness of Medicare rules and provide guidance to contractor beneficiary liaison staff

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